Supreme Court, U.S.
FILED

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No.

IN THE SUPREME COURT OF THE UNITED STATES

BRENT KAMLER,

Petitioner,

v.

H/N TELECOMMUNICATION SERVICES, INC., formerly known as PAL TELECOM GROUP, INC., formerly known as PAL WIRELESS DEVELOPMENT GROUP, INC.; ROYAL & SUNALLIANCE; and PAL TELECOM GROUP, INC., EMPLOYEE WELFARE PLAN,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether under federal common law, doctrines of estoppel apply to a claim under the Employee Retirement Income Security Act of 1974 (ERISA) to recover health insurance benefits, and, if so, what the elements of that estoppel are, so an ERISA claimant can recover health insurance benefits he was promised but which were denied him because of his employer's misleading and otherwise inequitable conduct, as to which the court of appeals are in conflict.

RULE 29.6 NOTATION

Petitioner is an individual so no Rule 29.6 disclosure is required.

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PETITION FOR WRIT OF CERTIORARI

Brent Kamler respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit in this case.

OPINIONS BELOW

The opinion and order of the district court (per Conlon, D.J.) (Appendix ("Pet. App."), *infra*, 24a-56a) granting summary judgment against petitioner is unreported but appears at 2001 WESTLAW 740516. The opinion of the court of appeals (per Cudahy, joined by Coffey and Williams) affirming (Pet. App., 1a-23a) is reported at 305 F.3d 672. The court of appeals' order denying rehearing and rehearing *en banc* (Pet. App. 57a) is not reported.

JURISDICTION

The jurisdiction of the district court was invoked under 29 U.S.C. § 1132(e) & (f) of the Employee Retirement Income Security Act of 1974 (ERISA) and under 28 U.S.C. § 1331 (1988). The judgment of the court of appeals was entered on September 16, 2002. A timely petition for rehearing with suggestion for rehearing *en banc* was denied on November 8, 2002. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Although this case primarily involves questions of ERISA common law, the relevant statutory provisions of ERISA are as follows:

29 U.S.C. § 1102(a)(1) provides:

> (a) Named fiduciaries
>
> (1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

29 U.S.C. § 1102(b)(3) provides:

> (b) Requisite features of plan
>
> Every employee benefit plan shall–
>
> . . .
>
> (3) provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan, ...

29 U.S.C. § 1132(a)(1)(B) provides:

> (a) Persons empowered to bring a civil action. A civil action may be brought–
>
> (1) by a participant or beneficiary–
> . . .
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the plan, or to clarify his rights to future benefits under the terms of the plan.

STATEMENT OF THE CASE

1. Introduction.

This is an ERISA case.

Petitioner Brent Kamler seeks to recover damages to cover still unpaid medical expenses which his former employer PAL Telecom Group, Inc. and its health insurer refused to pay on the ground that he was never enrolled in the health insurance plan. The issues involve the doctrine of "ERISA estoppel."

2. Procedural Background.

On July 3, 2000, petitioner filed this action in the United States District Court for the Northern District of

Illinois seeking to recover health insurance benefits so that he could pay medical expenses incurred from his June 1998 heart attack. His complaint asserted a claim to recover those benefits under 29 U.S.C. § 1132(a)(1)(B) of ERISA and under theories of equitable estoppel and breach of fiduciary duty.[1]

On June 29, 2001, the district court entered a Memorandum Opinion and Order that granted summary judgment against Mr. Kamler on various grounds, most importantly that he was not a "participant" in the health insurance plan and thus had no standing to assert ERISA claims because the form required to enroll in the plan was not submitted to the insurer and because, the court ruled, that failure was his fault. (Pet. App. 24a-56a *passim*).

A panel of the Seventh Circuit affirmed. First, it rejected the district court's holding on ERISA standing as based on abrogated precedent. (Pet. App. 8a-10a). Second, it held that petitioner had not met the required elements of that Circuit's definition of estoppel and was to blame for failure to submit the enrollment form required to perfect his coverage. (Pet. App. 10a-16a). Third, it ruled that PAL did not breach its fiduciary duties by delaying the enrollment process and by failing to warn Mr. Kamler that

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[1] This Petition does not involve Mr. Kamler's claim for statutory penalties on account of PAL's refusal to provide him information about the Plan during his pre-suit efforts to recover his benefits, also rejected by both the district court (Pet. App. 40a-47a) and court of appeals (Pet. App. 21a-23a).

he would not be insured if he did not submit the enrollment form. (Pet. App. 17a-20a). Fourth, it ruled that Mr. Kamler's claim for benefits was not saved by the policy's "clerical omissions" clause. (Pet. App. 20a-21a).

The court of appeals denied rehearing and rehearing *en banc* without explanation. (Pet. App. 57a).

3. Facts.

The panel complained that the facts are tangled. (Pet. App. 1a-2a). They are not.

Indeed, petitioner's case is especially simple because he is entitled to the benefit of all factual inferences in that this is a review of a grant of summary judgment against him.

Thus, when viewed in his favor, the facts are simply as follows:

In March 1998, Mr. Kamler, a highly skilled and experienced telecommunications construction manager, was persuaded to go to a remote province of Brazil by the oral pre-employment promise of one George Lamplota – a vice president of Mr. Kamler's soon-to-be employer PAL Telecom Group, Inc. (PAL) – that Mr. Kamler would have full health insurance before he left the country.

Mr. Kamler had applied for work with PAL several months earlier, but it was only when PAL had a sudden,

urgent emergency need for someone of his experience, including as it did, construction experience in Brazil, that Lamplota pulled Mr. Kamler's resume, telephoned him and in a few hours concluded the hiring negotiations, all by phone. (R63: Exhibit 8: Lamplota Dep. 15-18, 21-22, 83, 113).

The oral promise – During those negotiations, Lamplota promised that Mr. Kamler would have health insurance before he left the country for Brazil.

As Mr. Kamler testified:

> Well, I told Mr. Lamplota that I would not leave the country until I had full medical coverage; that I'm not going out of the United States, especially to a country that has tropical diseases, without medical insurance. (R63: Exhibit 1: Kamler Dep. 71, 87-89).

Lamplota responded "No problem" and said that Mr. Kamler "would be insured." (*Id.* 87-89, 141).

Lamplota then told another PAL vice-president that Mr. Kamler had said that he would not go to Brazil without health insurance. (R63: Exhibit 7: Sriver Dep. 72, 95).

Based on Lamplota's promise, Mr. Kamler left the United States two days after he accepted the job, and traveled by air 16 hours over three days to Joao Pessoa, Brazil.

Because he thought he was covered by PAL's health plan, he let his COBRA health insurance from his prior employer lapse. (R. 63: Ex. 1: Kamler Dep., 73-74, 89, 141, 164).

PAL did not maintain an office in Joao Pessoa, and communications between PAL's Chicago office and its Brazilian staff were very random. (R63: Exhibit 8: Lamplota Dep. 93-94). Using his hotel room as his base, Mr. Kamler spent most of his time in the field, generally working 80-100 hours a week. (R63: Exhibit 9: Jaworski Dep. 20; Exhibit 1: Kamler Dep. 143-44, 148).

Mr. Kamler's entitlement to coverage – The parties agree that Mr. Kamler was absolutely entitled to the health coverage under the PAL Plan and, under recent federal legislation, could not be refused coverage for any reason. Because of the Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. §§ 1181-82 and 42 U.S.C. § 300gg42 U.S.C. § 300gg-142 U.S.C. § 300gg-4142 U.S.C. 300gg, 300gg-1 & 300gg-41 (HIPPA), the insurer could not decline medical coverage due to any preexisting health status reasons.

The evidence also established without contradiction that Mr. Kamler's coverage was guaranteed, *i.e.*, the insurer "could not decline [applicants] for medical coverage after HIPA (*sic*)," and that the review of his application would be limited to the length of any pre-existing condition exclusion based on whether the application was timely or late. (R63-1: Pl's SJ Exs, Vol.

1: Exhibit 4: Wendell Dep. 57-58).

Therefore, the submission of the enrollment form was merely a ministerial act.

The written misrepresentation – Mr. Kamler heard and received nothing about his health insurance until six weeks later. In early May, Lamplota faxed him a package of documents related to enrollment. The fax was comprised of a cover sheet, an excerpt from PAL's employee manual and an incomplete enrollment form.

The cover sheet explicitly stated that Mr. Kamler's "coverage is to start by 05-01-1998." (R. 63: Exhibit 24: Lamplota fax). Mr. Kamler was surprised to learn that his coverage had not started until May 1, and relieved that nothing had happened earlier. As he recalled his reaction: "Thank God nothing happened in April." (R. 63: Exhibit 1: Kamler Dep. 90).

The personnel manual excerpt stated that PAL carried health insurance "on a Group Basis for the benefit of its employees," further confirming Mr. Kamler's understanding that he was covered (R. 63: Exhibit 24: Lamplota fax, p. 10).

The enrollment form was missing an important "Notice Under the Fair Credit Reporting Act"[2] that

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[2] 15 U.S.C. 1681b(c)(1) requires written authorization (continued...)

described an extensive investigation that the insurer might conduct into the personal affairs of the employee. This omission was important because the form required the employee to acknowledge that he or she had actually received a copy of that Notice. (Compare: R. 63: Exhibit 24: Lamplota Memo, Enrollment Form missing Notice with R. 63: Exhibit 19: Enrollment Form with Notice).

Nothing in the faxed package disclosed that Mr. Kamler would not be enrolled unless he submitted the form.

As soon as Mr. Kamler read the enrollment form, he telephoned Lamplota to complain and inquire why he was required to release such extensive personal information to the insurer, questions that would have been in large part answered had the "Notice Under the Fair Credit Reporting Act" not been omitted from the faxed form.

Lamplota promised to investigate and respond to Mr. Kamler's inquiries but never did. Instead, a month later, in early June, he fired Mr. Kamler, ostensibly for lack of work. (R63: Exhibit 8: Lamplota Dep. 166; Exhibit 1: Kamler Dep. 21, 84-87).

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[2](...continued)
before a consumer report could be ordered for this insurance transaction. 15 U.S.C. § 1681d(a)(1) requires this explicit notice be given to the consumer within three days of ordering an investigation, and the insurer's practice was to give that notice as part of the application process.

Mr. Kamler returned home to California and suffered a heart attack a few days later.

The hospital and doctors treated him without any evidence of insurance. (R.63: Exhibit 1: Kamler Dep. 35, 40; R83: Declaration of Brent Kamler). Their bills remain unpaid even today. Had he been insured, those expenses would have been covered because they were incurred within the same month that he left PAL's employ. R63: Exhibit 1: Kamler Dep. 21-22, 33, 27-28; R63: Exhibit 26: 8/4/98 Becker letter & invoices).

Under doctrines of estoppel long known to the common law, Mr. Kamler seeks to enforce PAL's promise that he would be fully insured.

REASONS FOR GRANTING THE PETITION

1. The federal circuits are hopelessly divided on whether ERISA estoppel exists and, if so, what its elements are.

The federal circuits are hopelessly split – splintered is a more apt term – about whether well-accepted common law doctrines of estoppel apply to employee benefits plans regulated under ERISA, and, if so what the elements of such "ERISA estoppel" are.

The Fifth and Sixth Circuits say there is no such thing as ERISA estoppel. *Williams v. Bridgestone/Firestone, Inc.*, 954 F.2d 1070, 1073 (5th Cir. 1992) (claims of

promissory or equitable estoppel not cognizable in ERISA actions); *Musio v. American General Corp.*, 861 F.2d 897, 910 (6th Cir. 1988), *cert. denied*, 490 U.S. 1020 (1989) (no oral modifications of plans); *Sprague v. General Motors Corp.*, 133 F.3d 388, 402-03 (6th Cir.) (*en banc*), *cert. denied*, 524 U.S. 923 (1998) (no modification of plan by oral representations or written statements that were not formal plan amendments).

The First Circuit at first ruled that there was no such a thing. *Law v. Ernst & Young*, 956 F.2d 364, 368 (1st Cir. 1992) (analyzes estoppel under tort principles; finds not established in case; declines to adopt 11th Circuit's *Kane*), but later decisions have stated that the existence of ERISA estoppel is an open question. *City of Hope National Medical Center v. Healthplus, Inc.*, 156 F.3d 223, 229-30 (1st Cir. 1998) (ERISA estoppel is an open question); *Mauser v. Raytheon Company Pension Plan for Salaried Employees*, 239 F.3d 51, 57 (1st Cir. 2001) (same).

It appears that the Tenth Circuit has also migrated from the strict "no estoppel" to the "open question" approach. *Compare*: *Straub v. Western Union Telegraph Co.*, 851 F.2d 1262 (10th Cir. 1988) (No formal or informal modifications even under doctrine of promissory estoppel) and *Miller v. Coastal Corp.*, 978 F.2d 622, 624-25 (10th Cir. 1992), *cert. denied*, 507 U.S. 987 (1993) (no ERISA estoppel in Tenth Circuit) *with Cannon v. Group Health Service of Oklahoma, Inc.*, 77 F.3d 1270, 1276-77 (10th Cir. (10th Cir.), *cert. denied*, 519 U.S. 816 (1996) ("This court has neither adopted nor rejected an equitable

estoppel rule in the ERISA context."). But at least one Tenth Circuit decision suggests that the only open question is whether estoppel will lie in "extraordinary circumstances." *Kaferly v. U.S. West Technologies*, 189 F.3d 478 (Table - (unpublished Disposition), 1999 WL 679682, *10 (10th Cir. 1999).

The Eleventh Circuit holds that oral modifications of ERISA plans are enforceable only if they are merely interpretations of ambiguous plan provisions. *Kane v. Aetna Life Insurance,* 893 F.2d 1283 (11th Cir.), *cert denied*, 498 U.S. 890 (1990), and the Eighth and Ninth Circuits have concurred. *Slice v. Norway*, 34 F.3d 630, 634-35 (8th Cir. 1994) (adopts reasoning of First Circuit in *Law* that no estoppel; erroneous written statement of benefits not shown to merely hold employer to plausible interpretation rather than modification of plan); *Fink v. Union Central Life Insurance Co.*, 94 F.3d 489, 493 (8th Cir. 1996) (estoppel available only to interpret ambiguous plan terms). *Greany v. Western Farm Bureau Life Ins. Co.*, 973 F.2d 812, 821-22 (9th Cir. 1992) (equitable estoppel available only when statements interpret ambiguous plan provisions, adopting Eleventh Circuit's rationale in *Kane*).

In the Fourth Circuit, there is authority on both sides of the question. *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54, 58-60 (1992), *cert. denied*, 506 U.S. 1081 (1993) (equitable estoppel not available to orally or informally modify terms of plan); *Elmore v. Cone Mills Corp.*, 23 F.3d 855 (1994) (*Elmore I*) (*en banc)* (estoppel available

on showing of detrimental reliance) (affirmance & remand by equally divided court) (concurrence by Murnaghan, J.), *appeal after remand*, 187 F.3d 442, 446-48 (4th Cir. 1999) (*Elmore II*) (employee failed to show detrimental reliance); *Bakery and Confectionery Union and Industry International Pension Fund v. Ralph's Grocery Co.*, 118 F.3d 1018 (4th Cir. 1997) (No ERISA equitable estoppel in Fourth Circuit - *dicta* in dispute by multiemployer plan to recover delinquent payments from employer).

The Seventh Circuit whence this case comes, and the Second and Third Circuits have recognized the doctrine but differ significantly on its elements.

Acknowledging the confusion in the Seventh Circuit about ERISA estoppel, (Pet. App. 12a), the panel asserted that *Coker v. Trans World Airlines,* 165 F.3d 579, 585 (7th Cir. 1999), had "attempt[ed] to clarify [that] confusion" by definitively stating the elements of ERISA estoppel to be:

(1) a knowing misrepresentation by the defendant;
(2) in writing;
(3) with reasonable reliance by the plaintiff on the misrepresentation;
(4) to the plaintiff's detriment. (Pet. App 12a).

Relying on *Bowerman v. Wal-Mart Stores, Inc.,* 226 F.3d 574, 588 (7th Cir. 2000), the panel concluded that Lamplota's oral promises of coverage could not be the basis of estoppel because those promises were not interpretations of ambiguous provisions of the PAL plan,

the only circumstance which the panel said permitted estoppel on oral statements. (Pet. App. 16a).

The Second Circuit's standards of estoppel which are much more realistic and worldly are:

(1) a promise;
(2) reliance on the promise;
(3) injury caused by the reliance;
(4) an injustice if the promise is not enforced, and
(5) 'extraordinary circumstances.'

Devlin v. Empire Blue Cross and Blue Shield, 274 F.3d 76, 85-86 (2d Cir. 2001); *Aramony v. United Way Replacement Benefit Plan*, 191 F.3d 140, 151 (2d Cir. 1999) and *Schonholz v. Long Island Jewish Medical Center*, 87 F.3d 72, 79 (2nd Cir.), *cert. denied*, 519 U.S. 1008 (1996); and *Devlin v. Transp. Comms. Int'l Union*, 173 F.3d 94, 102 (2d Cir. 1999).

The rule of the Third Circuit is the same. *Curcio v. John Hancock Mut. Life Ins. Co.*, 33 F.3d 226, 235 (3d Cir. 1994); *Smith v. Hartford Ins. Group*, 6 F.3d 131, 137 (3d Cir. 1993) citing *Gridley v. Cleveland Pneumatic Co.*, 924 F.2d 1310, 1319 (3d Cir.), *cert. denied*, 501 U.S. 1232 (1991).

This Second and Third Circuit jurisprudence also suggests that extraordinary circumstances might be shown by intentional or devious conduct by the promisor. *Devlin*, 274 F.3d at 85-86; *Schonholz*, 87 F.3d at 79-80. The

statement is nearly the same in the Third Circuit. *Int'l Union, United Auto., Aerospace & Agr. Implement Workers of America, U.A.W. v. Skinner Engine Co.*, 188 F.3d 130, 152 (3d Cir. 1999) (Extraordinary circumstances shown by affirmative acts of fraud or similarly inequitable conduct by an employer, misrepresentations over an extended course of dealings or the vulnerability of particular plaintiffs).

The rules could not be more different.

Thus, the split and confusion between and among the circuits is a hopeless muddle and requires this Court's intervention.

2. As shown by the maturing views of the lower federal courts, the common law doctrine of estoppel should be applied to protect employee benefits.

The tension in this case – and the fundamental basis of the circuit split – arise first from ERISA's explicit requirements that all plan modifications be written, 29 U.S.C. § 1102(a)(1), and be promulgated pursuant to certain required procedures, 29 U.S.C. § 1102(b)(3). Thus, the decisions rejecting ERISA estoppel do so primarily on the grounds that oral misrepresentations do not satisfy the writing requirement and/or that written misrepresentations do not fulfill the procedural requirements. *See e.g. Hozier v. Midwest Fasteners, Inc.*, 908 F.2d 1155, 1163 (4th Cir. 1990) (no oral amendments of plan) and *Sprague*, 133 F.3d

at 402-03) (no oral modification of plan and written statements were not formal plan amendments).

The initial judicial reluctance to apply a federal common law estoppel doctrine to ERISA also stemmed from a concern for the actuarial soundness of ERISA plans. *Black v. TIC Investment Corp.*, 900 F.2d 112, 115 (7th Cir. 1990); *Chambless v. Masters, Mates & Pilots Pension Plan*, 772 F.2d 1032, 1041 (2nd Cir. 1985), *cert. denied*, 475 U.S. 1012 (1986) and *Phillips v. Kennedy*, 542 F.2d 52, 55 n. 8 (8th Cir. 1976).

However, as the Seventh Circuit noted in *Black*, estoppel generally applies to all legal actions; it is the exception to deny the use of the doctrine. *Black* sounds the refrain familiar to all variants of estoppel: "The reasons for the general application of estoppel are simple enough--the doctrine prevents a party from benefitting from its own misrepresentations." 900 F.2d at 115.

Thus, because of the recurring cases of unjust denials of plan benefits, the initial reluctance to apply estoppel to ERISA began to fall. The doctrinal authority for that change of heart was the Congressional mandate, recognized repeatedly by this Court, that the federal courts must develop a federal common law of ERISA on questions not specifically addressed by the statute. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989). Simply stated, the question presented in this case and not addressed by ERISA is: what happens when a plan

participant is denied benefits because of misconduct of the employer, administrator or insurer.

Those circuits which have answered that question by invoking estoppel are the truest to the fundamental policy of the statute: protection of employee benefits. 29 U.S.C. 1001(b); *Pilot Life Ins. Co.,* 481 U.S. at 44.

3. The proper rule of estoppel herein excuses the requirement of the enrollment form because of the employer's misconduct.

The conflict and confusion between and among the circuits is also born of an intermingling of the variants of estoppel.

The first intermingling involves the differing concepts of promissory estoppel and equitable estoppel.

The court of appeals herein asserted without explanation that the Seventh Circuit's formulation of ERISA estoppel encompasses promissory estoppel. (Pet. App. 12a). In contrast, the Second Circuit's leading decisions explicitly cite and discuss the promissory estoppel sections of the first and second Restatements of Contracts that set forth the elements of that variant. *See e.g. Schonholz*, 87 F.3d at 78-79 (discussing the *Restatement of Contracts* § 90 (1932) and *Restatement*

(Second) of Contracts § 90(1) (1979)).[3] On the other hand, the Third Circuit's leading decision cites Section 90 of the *Restatement (Second) of Contracts* describing promissory estoppel, but then states the rule as being one of equitable estoppel. *Curcio*, 33 F.3d at 240-41.

While promissory estoppel is of the same species as equitable estoppel, the two are different creatures. Promissory estoppel is a quasi-contract doctrine that generally cures the absence of consideration for a bargain. Its elements are an unambiguous promise, reasonable and foreseeable reliance, and damages. *See e.g.*, *Holy Cross Hosp. v. Bankers Life and Cas. Co.*, 2002 WL 31507164, *8 (N.D. Ill. 2002).

In contrast, equitable estoppel involves a misrepresentation on which a plaintiff reasonably relies to his or her detriment. This concept of estoppel from a misrepresentation arises in two contexts: in tort and in contract law.

The tort incarnation of equitable estoppel is reflected in the First Circuit's ERISA estoppel analyses that invoked

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[3] Section 90 of the Restatement (Second) of Contracts provides: "(1) A promise which the promisor should reasonably expect to induce action or forbearance on the part of the promisee or a third person and which does induce such action or forbearance is binding if injustice can be avoided only by enforcement of the promise. The remedy granted for breach may be limited as justice requires."

Section 894(1) of the *Restatement of Torts*.[4] *Law v. Ernst & Young*, 956 F.2d at 368; *City of Hope*,156 F.3d at 231. It is generally defensive in nature and prevents one who made a misrepresentation from maintaining an action in tort against, or recovering property or its value from, a person to who reasonably relied on that misrepresentation to his or her detriment.

The contract incarnation of equitable estoppel from a misrepresentation arises in the context of unjustly preventing or hindering the other party's performance of a contract condition or requirement.

The essence of estoppel in contract law, is simply that the non-occurrence of a condition "may be excused by prevention or hindrance of its occurrence through a breach of the duty of good faith and fair dealing." *Restatement*

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[4] Section 894(1) of the Restatement of Torts provides:

If one person makes a definite misrepresentation of fact to another person having reason to believe that the other will rely upon it and the other in reasonable reliance upon it does an act that would not constitute a tort if the misrepresentation were true, the first person is not entitled

(a) to maintain an action of tort against the other for the act, or

(b) to regain property or its value that the other acquired by the act, if the other in reliance upon the misrepresentation and before discovery of the truth has so changed his position that it would be unjust to deprive him of that which he thus acquired.

(Second) of Contracts § 225, comment b (1981). *See also Id.* § 205 comment d (good faith in performance includes non-hindrance of other party's performance).

As Professor Corbin taught: "[o]ne who unjustly prevents the performance or the happening of a condition of his own promissory duty thereby eliminates it as such a condition. He will not be permitted to take advantage of his own wrong. . . ." *Corbin on Contracts* § 767 (1960).

Although the court below ignored that doctrine in resolving this case, earlier cases the Seventh Circuit have explicitly adopted it.

In *Bowerman v. Wal-Mart Stores, Inc.,* 226 F.3d at 586, the Seventh Circuit excused an employee's failure to pay a required COBRA premium because the employer and insurer misinformed her that she was already covered and that the payment was not required. *Swaback v. American Info. Techs. Corp.*, 103 F.3d 535, 542-43 (7th Cir. 1996), concluded that a widow could claim her deceased husband's lump sum retirement benefits because his failure to make a required election was caused by misinformation from the employer.

The "basic policy consideration arguing in favor of applying estoppel is the principle of contract law that 'a party who prevents the occurrence of a condition precedent may not stand on that condition's nonoccurrence to refuse to perform his part of the contract.'" *Bowerman*, 226 F.3d at 586, quoting *Swaback*, 103 F.3d at 543-44, n. 17; and

Gallegos v. Mount Sinai Med. Ctr., 210 F.3d 803, 811 (7th Cir.), *cert. denied*, 531 U.S. 827 (2000)

So too has the Third Circuit invoked this rationale in a case virtually on all fours with this one. *Epright v. Environmental Resources Management, Inc. Health and Welfare Plan*, 81 F.3d 335 (3d Cir. 1996).[5]

In *Epright*, a plan administrator denied payment of medical expenses because the employee had failed to submit the required enrollment forms. The Third Circuit excused the performance of that condition on two grounds: first, because submission of the forms was merely ministerial, and second, because the employer misrepresented coverage eligibility and misled the employee into not submitting the forms. As the Third Circuit, concluded on this second point:

> To the extent that completed enrollment forms are a prerequisite to eligibility for Plan benefits, such a requirement is excused in the instant case as their lack of existence is due to the defendant's mistake, and not the plaintiff's. *Id.* at 341.

Although without citation to the Restatement or to Professor Corbin, the *Epright* court analogized this holding to the contract law doctrine that "failure to satisfy a condition should be excused if the other party thwarted

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[5] Petitioner notes that the U.S. Department of Labor filed an *amicus* brief in support of Epright, the insured. *Id.* at 335 & 341.

fulfillment of the condition." *Id.* n. 1.

Petitioner believes that this latter rule is the proper one in this case. It was PAL and Lamplota who interfered and delayed and prevented petitioner's timely submission of the enrollment form leading to the denial of coverage.

Indeed, it is apparent that such a result would not be an amendment of the plan and would therefore avoid the concerns of the various circuits arising from the 29 U.S.C. §§ 1102(a)(1) and 1102(b)(3) which require written plans be amended only by established procedures. *See* Argument, Section 2, *supra*, p. 15-17. Plan amendments are legislative in nature and apply to all participants and beneficiaries. The application of equitable estoppel in this case would be *sui generis* applicable only to this case, and would reflect merely a judicial refusal to enforce a condition of coverage against one participant on the grounds of the traditional notions of equity encompassed in the concept of estoppel.

However, as Fourth Circuit Judge Murnaghan explained in his concurrence in *Elmore I*, 23 F.3d at 868 n. 5, the differing concepts of estoppel are often "conflated." Whatever the final rule adopted, this confusion and conflict requires resolution by this Court.

4. This Court's prior estoppel decisions in other contexts inform the analysis of this case.

The essence of all forms of estoppel is the misleading

or unfair conduct of a party that induces another to act to his or her detriment.

That underlying concept is clearly reflected in decisions of this Court that have dealt with various forms of estoppel.

It is reflected in the line of decisions wherein private parties have sought to prevent the government from asserting some sort of claim or defense contrary to an earlier position or pronouncement. *Heckler v. Community Health Services*, 467 U.S. 51, 59 (1984).

While the context is strikingly different because it is hard to estop the government, this Court's discussion of the elements of that tort concept of estoppel provide a useful starting point. "Estoppel is an equitable doctrine invoked to avoid injustice in particular cases. While a hallmark of the doctrine is its flexible application, certain principles are tolerably clear." Those principles are: reasonable reliance on a misrepresentation by an adversary which induced a change of position that would be unjust to undo. *Heckler*, 467 U.S. at 59.

This Court has invoked another version of estoppel – judicial estoppel – which captures the same policy: it is unjust to allow a litigant to assume a position to that previously maintained, especially if it be to the prejudice of the party who has acquiesced in the former position. *New Hampshire v. Maine*, 532 U.S. 742, 749 (2001).

Yet another line of this Court's "equitable estoppel" cases involves statutes of limitations. The underlying question is essentially the same: whether it is unfair to enforce a limitations period against a plaintiff who was lulled by a defendant into letting the filing period lapse. As this Court said in *Glus v. Brooklyn Eastern Dist. Terminal*, 359 U.S. 231, 232-233 (1959):

> To decide the case we need look no further than the maxim that no man may take advantage of his own wrong. Deeply rooted in our jurisprudence this principle has been applied in many diverse classes of cases by both law and equity courts and has frequently been employed to bar inequitable reliance on statutes of limitations.

See also Schroeder v. Young, 161 U.S. 334, 344 (1896) ("[T]he courts have held with great unanimity that the purchaser is estopped to insist upon the statutory period, notwithstanding the assurances were not in writing, and were made without consideration, upon the ground that the debtor was lulled into a false security.")

Finally, that important policy is reflected in a context quite close to this case: the pre-*Erie* insurance decision in *Union Mut. Ins. Co. v. Wilkinson*, 80 U.S. 222, 233 (1871), in which Justice Miller wrote that "the general doctrine [of equitable estoppels, or, as it is sometimes called, estoppels *in pais*] is well understood and is applied by courts of law as well as equity where the technical advantage thus obtained is set up and relied on to defeat the ends of justice

or establish a dishonest claim."

Petitioner notes that these analogous pronouncements by this Court sound the refrain followed by the Second and Third Circuits' decisions in the ERISA context presented herein and will provide a useful guidance toward the essential principles of estoppel – flexibility and prevention of an injustice.

Those decisions will inform this Court's analysis and lead to the just result: reversal of the summary judgment against petitioner and a remand for a trial.

5. Application of the correct rule of estoppel entitles petitioner to a trial.

If the proper standard of estoppel is applied herein, Mr. Kamler has a triable case that should not have been subject to summary judgment.

When properly viewed, the evidence clearly showed that he was unconditionally promised coverage prior to his departure for Brazil. There is also no question that he relied on that promise, leaving the country, as he did, at once and letting his prior health insurance coverage lapse.

Furthermore, extraordinary circumstances are extant on this record: Mr. Kamler left California at the drop of a hat and traveled to a remote corner of Brazil to solve PAL's emergency need for an experienced construction manager on a problem project and let his prior health

coverage lapse. To the extent that the element of "extraordinary circumstances" requires some element of culpability or blame by PAL, Mr. Kamler is entitled to the inference that Lamplota and PAL took advantage of him to get him to the Brazilian project as soon as possible.

Finally, it is absolutely clear that Mr. Kamler has a compelling case that it was PAL and Lamplota who unfairly delayed and hindered, and ultimately prevented, Mr. Kamler's submission of the enrollment form, a requirement that was merely ministerial in nature.

Moreover, the panel below misconstrued the facts so they would not fulfill the elements of estoppel.

First, the panel described Lamplota's oral promise as follows: "Lamplota allegedly responded that Kamler would be insured." (Pet. App. 2a). This hedged understatement wrings the importance from Lamplota's unequivocal promise of coverage. It ignores the strong corroborative evidence that Lamplota explicitly acknowledged to another PAL vice-president that Mr. Kamler refused to leave the country without coverage. It ignores the written statement in Lamplota's fax that "coverage to start by 05-01-1998." It misapplies the rule that on review of summary judgment Mr. Kamler was entitled to the benefit of all factual inferences. The only proper view at this stage of the case is that Lamplota unequivocally told Mr. Kamler that he would be fully insured before he left for Brazil.

Second, the panel's holding that Mr. Kamler did not reasonably rely on the promises of coverage (Pet. App. 13a-15a) was also completely wrong. The panel focused only on the documents and statements in the package of documents faxed to Mr. Kamler in early May. This is a curious error of analysis because Mr. Kamler had already relied on Lamplota's oral misrepresentation of coverage which induced him to leave the U.S., travel to Brazil, begin work on this difficult project, and let his COBRA health insurance coverage lapse. His reliance was complete by the time he received the faxed enrollment package. Moreover, the panel's discussion of the plan's constituting documents is inexplicable. In fact, those documents are irrelevant to the estoppel analysis because Mr. Kamler did not see any of them.

Third, the panel's parsing of the "Waiver of Coverage" language on the rear of the incomplete second generation faxed enrollment form is strained to say the least. (Pet. App. 15a). That provision simply does not say that a new employee will not be covered if he of she does not submit the enrollment form.

Fourth, the panel's assertion that Mr. Kamler did not allege that he was told he did not have to apply (Pet. App. 19a) turns the evidence on its head. Mr. Kamler's position has always been that he was explicitly promised that he was covered and that he was **not told** that he must submit the enrollment form to obtain that coverage.

Fifth, the panel was incorrect in asserting that Mr.

Kamler's reliance was not reasonable because he had never obtained insurance without filling out a form (Pet. App.13a): he had in fact obtained health coverage under almost identical circumstances – prior to formal enrollment. (R63: Exhibit 1: Kamler Dep. 113-14). Furthermore, the PAL plan itself provided for just such procedures to correct or update coverage mistakes after the onset of a covered claim.[6]

Finally, the panel wrongly held that it was unreasonable for Mr. Kamler to delay completing the enrollment form as he waited for a response to his privacy concerns. Privacy concerns are a material part of state[7]

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[6] Under the Plan documents, PAL could request that the waiting period be waived (R63: Exhibit 15: Guide p. 5, section 106). Furthermore, the policy provided for amelioration of errors in enrolling due to clerical error - a provision that clearly applied to the omission of the Fair Credit Reporting Act Notice from the faxed enrollment form. (R63: Exhibit 11: Policy p. 45, IX(D)).

[7] The Illinois Medical Patient Rights Act establishes a "right of each patient to privacy and confidentiality in health care" and provides that "[e]ach physician, health care provider, health services corporation and insurance company shall refrain from disclosing the nature or details of services provided to patients . . . ." 410 ILCS § 50/3.

The Illinois Genetic Information Privacy Act, 410 ILCS 513/1 *et seq.*, prohibits the dissemination of genetic information.

Article XL ("Insurance Information Privacy and Protection") of the Illinois Insurance Code extensive regulates an insurer's (continued...)

and federal[8] health insurance law, and Mr. Kamler's inquiries invoked the protections of those laws and were *ipso facto* reasonable.

In summary, the panel's contortions of the facts ensured that Mr. Kamler could not prove estoppel.

6. Certain fiduciary duty issues will be subsumed in the grant of certiorari on estoppel.

Petitioner does not seek certiorari on the court of appeals' fiduciary duty ruling (Per App. 17a-20a). However, aspects of that ruling will be "fairly included," Sup. Ct. R. 14.1(a), in the grant of certiorari on estoppel because PAL's misconduct justifying estoppel also breached its fiduciary duties to petitioner, *inter alia*, to (1) process his enrollment promptly, (2) provide him with an enrollment form that included the "Notice under the Fair Credit Reporting Act," (3) warn that he would not be

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[7](...continued)
accumulation and use of personal information about insureds. 251 ILCS § 5/1001, *et seq.*

[8] The Fair Credit Reporting Act contains extensive federal regulation of personal information obtained by insurers. 15 U.S.C. § 1601, *et seq.*

Title V of the Gramm-Leach-Bliley Financial Modernization Act provides for the protection of personal information by insurers. 15 U.S.C. § 6801, *et seq.*

covered unless he submitted the enrollment form, (4) pay his premiums, and (5) respond to his privacy concerns.

Notwithstanding the court of appeals' contrary conclusions (Pet. App. 17a-20a), that misconduct breached PAL's fiduciary duty to Mr. Kamler. *See e.g.* 29 U.S.C. § 1104(a)(1) (fiduciary must act "solely in the interest of the participants and beneficiaries) and *Anweiler v. Am. Elec. Power Serv. Corp.*, 3 F.3d 986, 991 (7th Cir.1993) (misleading plan participants or misrepresenting terms or administration of plan is a breach of fiduciary duty).

Petitioner stresses this so that the issue is within the grant of certiorari. *Yee v. City of Escondido*, 503 U.S. 519, 535-36 (1992).

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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FEBRUARY 2003

APPENDIX A

In the
United States Court of Appeals
For the Seventh Circuit

No. 01-2995

BRENT KAMLER,

Plaintiff-Appellant,

v.

H/N TELECOMMUNICATION SERVICES, INC., et al.,

Defendants-Appellees.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 00-C-4024—**Suzanne B. Conlon**, *Judge*.

ARGUED APRIL 16, 2002—DECIDED SEPTEMBER 16, 2002

Before CUDAHY, COFFEY and WILLIAMS, Circuit Judges.

CUDAHY, *Circuit Judge*. In this appeal, Brent Kamler challenges a grant of summary judgment entered against him on his ERISA-related claims against H/N Telecommunication Services, Inc., formerly known as PAL Telecom Group, Inc. (PAL), PAL Telecom Group, Inc. Employee Welfare Plan (PAL Plan) and Royal & SunAlliance (Royal). This case presents a tangled factual

scenario which we will try to untangle as best as we can.

I.

The relationship between Kamler and PAL arose when PAL decided to hire three managers for a construction project in Brazil. George Lamplota, PAL's director of project management, telephoned Kamler for an initial telephone interview. During this interview, Kamler asked Lamplota for an annual salary of $95,000, full medical benefits plus per diem expenses. Kamler, who resides in California, demanded health insurance before he would go to Brazil. Lamplota allegedly responded that Kamler would be insured. Lamplota offered Kamler medical benefits under the PAL Plan, but there is a factual dispute about whether Kamler stated that he did not want PAL's health insurance if he had to pay premiums. *See Kamler v. H/N Telecommunication Serv., Inc.*, No. 00-C-4024, 2001 WL 740516, *1 (N.D. Ill. June 29, 2001).

On March 17, Kamler signed a letter of commitment memorializing the agreement with respect to his compensation package, but this letter is silent about health insurance coverage. Two days later, Kamler left for Brazil. A short time later, Lamplota obtained a personnel manual and an enrollment form for the PAL Plan for Kamler, which was to be faxed via PAL's office in Sao Paolo, Brazil. The personnel manual's section on insurance states "medical, life and long-term disability

insurance are carried by the firm on a group basis for the benefit of its employees." *Kamler,* 2001 WL 740516, at *2.

The PAL Plan was an employee welfare benefit plan established by PAL for eligible employees through participation in a group medical, life and disability insurance program. The PAL Plan is governed by the Employee Retirement Income Security Act (ERISA). The PAL Plan was underwritten by Trustmark Insurance Company and administered by Star Marketing & Administration, Inc. (Starmark). *Kamler,* 2001 WL 740516, at *3. The Plan provided that all eligible employees must apply for coverage by filling out an enrollment form. *Id.* If an employee applied before working 30 continuous days, his effective date occurred at the end of the 30-day period, and if he applied after this date, the effective date was the first day of the month following the date he applied. *Id.* This 30-day period could be waived by a request submitted with the enrollment form. *Id.* The enrollment form provided in part:

> To be completed by the employees only. Failure to provide complete facts may be cause for cancellation of your coverage as of its effective date.
> NOTE: As part of our routine underwriting procedure, you may receive a phone call ... to obtain

> personal information needed to evaluate your insurability .... Unless waived above, I request insurance under my employer's insurance plan .... I authorize my employer to make deductions from my earnings for my share of the cost, if any, for the benefits for which I may become entitled.

Kamler, 2001 WL 740516, at *4. The PAL Plan also provided that, after an employee filled out an enrollment form and was accepted by Trustmark (the insurance company providing coverage), the employee would receive a certificate of insurance.

On March 30, Lamplota faxed the personnel manual and enrollment form to Victor Jaworski in PAL's Brazil office with the following cover memorandum:

> Victor: Enclosed please find [PAL's] ... Personnel Manual and the Employee Enrollment Form (Insurance) to be forwarded to Brent Kamler .... [He] should fill out the Employee Enrollment Form and return it back to me as soon as possible, the coverage is to start by 05-01-1998.

Kamler, 2001 WL 745016, at *3. Jaworski did not recall receiving this fax before May 1998.

On May 5, Lamplota resent the March 30th memorandum with the attachments to Jaworski. *Id.* On

May 6, Jim Oliva faxed this information to Kamler's hotel in Brazil, with a cover note that read: "Hi Brent: I was asked by Victor [Jaworski] to follow up on George Lamplota's fax. Please fill out the requested forms and fax back to Sao Paulo office." *Id.* Oliva then followed up with a phone call to Kamler.

After Kamler received the enrollment form, he promptly called Lamplota with questions about it. This was the first time since his initial telephone interview in mid-March 1998 that Kamler had discussedhealth insurance coverage with Lamplota. *Id.* Kamler told Lamplota that he was concerned that the enrollment form required him to provide information that he felt violated his right of privacy. Kamler asked Lamplota for verification of exactly what information the insurance company wanted, and why. Lamplota told Kamler that he would contact the insurance company and call Kamler back. Lamplota did not tell Kamler that Kamler would not receive coverage without filling out and submitting the form. Lamplota also did not advise Kamler to contact Starmark or anyone else for answers to his questions. Lamplota allegedly did not call Kamler back with answers to his inquiries, and Kamler never completed the enrollment process.

On June 3, 1998, Lamplota telephoned Kamler to terminate him because Kamler had completed his assignment early and there was no further work to do.

Kamler returned to the United States. Two weeks later, Kamler had a heart attack and was admitted to a hospital for treatment. On his hospital bill, the name of his insurance carrier is blank because he was never able to provide the hospital with the information. *Id.*

On August 4, 1998, Kamler submitted a claim to PAL (but not to the PAL Plan) for payment of the medical expenses arising from his heart attack. This claim was subsequently submitted, either by Kamler or PAL, to Royal (PAL's liability insurance carrier). Neither PAL nor the PAL Plan has ever paid Kamler's medical expenses.

In October 1999, CH2M HILL Telecommunications Group, LLP ("Hill"), and PAL transitionally merged, and in October 2000, Hill purchased PAL's assets. *Kamler,* 2001 WL 740516, at *5. On December 31, 1999, the PAL Plan was terminated. *Id.* The former PAL employees were covered under a new group plan that used a different insurance carrier than the PAL Plan did. *Id.*

On March 6, 2000, Lamplota received a letter from Kamler's attorney requesting the PAL Plan insurance documents. *Id.* The letter was referred by Lamplota to Nestor Popowych, the president of PAL, and eventually to legal counsel. It was then passed on to Royal. On November 24, Royal denied Kamler's claim for payment of his hospital bill based upon the results of its investigation. Kamler never contacted Starmark, and no one requested

information regarding the PAL Plan or submitted a claim for benefits to Starmark.

On March 20, 2001, Kamler filed his second amended complaint against PAL, the PAL Plan, Royal and Starmark. The defendants moved for summary judgment. The district court granted the motion. The district court held that Kamler did not have standing to bring a claim for medical benefits because Kamler was not a participant in the PAL Plan. In connection with the issue of standing, the district court held that Kamler did not have a colorable claim for medical benefits because alleged misrepresentations on the part of an employer's agents are insufficient to provide standing. Alternatively, Kamler did not have standing because he failed to satisfy his duties of self help and due diligence by neglecting to file his enrollment papers with Starmark. The district court also denied the claim for statutory penalties against PAL and Royal for failure to respond to a request for information. It concluded that Kamler should have made his request for information to Starmark, rather than to PAL or Royal. Moreover, the information requested was outdated since the PAL Plan had been terminated over a year and half earlier, andthe request was made very late. Subsequently, the claims against Starmark were dismissed by stipulation of settlement. Kamler appeals from the judgment of the district court on the remaining claims against PAL, the PAL Plan and Royal.

II.

This court has jurisdiction under 28 U.S.C. § 1291. We review the grant of a motion for summary judgment de novo, drawing all reasonable inferences in favor of the non-movant. *Neuma, Inc. v. AMP, Inc.*, 259 F.3d 864, 871 (7th Cir.2001). We will affirm a grant of summary judgment if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed.R.Civ.P. 56(c); *see also Neuma,* 259 F.3d at 871. *Cf. Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 114, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989) (holding that generally, "a denial of benefits challenged under § 1132(a)(1)(B) [of ERISA] is to be reviewed ... de novo"). We review a district court decision to impose or not to impose statutory penalties for an abuse of discretion. 29 U.S.C. § 1132(c)(1); *see also Neuma,* 259 F.3d at 879.

A.

Kamler seeks to recover his medical expenses from PAL and the PAL Plan under 29 U.S.C. § 1132(a)(1)(B).[1]

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[1] 29 U.S.C. § 1132 provides:

(a) Persons empowered to bring a civil action. A civil action may be brought--

(continued...)

Because the PAL Plan is governed by ERISA, Kamler must first establish that he has standing to bring these claims. Under ERISA, only participants can bring a claim against a plan for benefits. *See Firestone,* 489 U.S. at 116, 109 S.Ct. 948. A participant is a "former employee ... who is or may become eligible to receive a benefit of any type from an employee benefit plan." 29 U.S.C. § 1002(7). Further, persons who have "a reasonable expectation of returning to covered employment" or who have a "colorable claim to vested benefits" also have standing to bring ERISA claims. *Firestone,* 489 U.S. at 117, 109 S.Ct. 948 (internal quotations omitted). Because Kamler is neither currently employed by PAL nor expected to be employed by PAL, he is a participant only if he has a "colorable claim to vested benefits." We have held that the requirements for a colorable claim are not stringent; a plaintiff need have only a nonfrivolous claim for the benefit in question. *Panaras v. Liquid Carbonic Indus. Corp.,* 74 F.3d 786, 790 (7th Cir.1996).

Kamler argues that he has a colorable claim for benefits--and thus standing--under the alternative theories

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[1](...continued)

(1) by a participant or beneficiary--

. . .

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the plan, or to clarify his rights to future benefits under the terms of the plan.

of estoppel and breach of fiduciary duty. We have previously noted that "ERISA's standing requirements put this court in the rather unusual position of having to adjudicate the merits of the case at a fairly preliminary stage of the proceedings." *Sallee v. Rexnord Corp.*, 985 F.2d 927, 930 (7th Cir.1993). Based upon our analysis of Kamler's alternative theories for standing, *see infra,* we are inclined to disagree with the district court and hold that Kamler has standing because he has stated nonfrivolous claims for benefits.[2]

B.

First, Kamler argues that he is entitled to medical benefits under the PAL Plan because, except for the misrepresentations by PAL, the PAL Plan or their agents, he would have enrolled in the PAL Plan. Kamler's argument is based on several species of estoppel.

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[2] We note that the district court's reliance on *Loechl v. Illinois Bell Telephone Co.*, 648 F. Supp. 1178 (N.D. Ill.1986) and *Freeman v. Jacques Orthopaedic & Joint Implant Surgery Med. Group*, 721 F.2d 654 (9th Cir.1983), is misplaced in light of cases such as *Bowerman v. Wal- Mart Stores, Inc.*, 226 F.3d 574 (7th Cir.2000), which permitted a plaintiff, who stated a claim based upon misrepresentation, to prevail on an ERISA claim. *Loechl* and *Freeman* were decided before *Firestone*, which this court has interpreted to extend standing to any plaintiff with a colorable claim for benefits. *See Panaras*, 74 F.3d at 786.

The first is an equitable estoppel theory. Kamler argues that the defendants represented to him that he was already insured. For example, Lamplota, during the March 1998 phone interview, allegedly assured Kamler that Kamler would receive health insurance. The cover letter of the memo faxed by Lamplota to Jaworski in May 1998, and faxed on to Kamler, also allegedly represented that Kamler had health insurance beginning in May 1998. Finally, the personnel manual, faxed with the memorandum, allegedly represented that Kamler was already insured when it stated that "medical, life and long-term disability insurance are carried by the firm on a group basis for the benefit of its employees." Thus, Kamler argues that, if it had not been for these misrepresentations that he was already insured, he would have filled out an enrollment form.

Alternatively, Kamler argues that the defendants prevented him from enrolling and thus they should be estopped from denying him benefits that he would have received if he had enrolled. Besides representing to him that he was already insured (and thus implying that he did not need to enroll), Kamler argues that Lamplota's failure to call him back to answer his privacy concerns was a misrepresentation that resulted in Kamler's failure to complete the enrollment process. Finally, Kamler makes a promissory estoppel claim. He argues that PAL, through its agent Lamplota, promised him medical benefits and that he relied on this promise when he accepted employment and left for Brazil.

"It is not easy to apply estoppel principles to ERISA cases in the face of the rule requiring modifications to plans to be in writing, 29 U.S.C. § 1102(a)(1), and the required procedures for amending plans, 29 U.S.C. § 1102(b)(3)." *Coker v. Trans World Airlines,* 165 F.3d 579, 585 (7th Cir.1999). This court has, however, permitted plaintiffs to raise estoppel- based causes of action under ERISA. *See, e.g., Bowerman v. Wal-Mart Stores, Inc.,* 226 F.3d 574 (7th Cir.2000) (holding that a plan administrator was estopped from denying medical coverage where the plan documents were ambiguous and someone with apparent authority to interpret the plan made oral misrepresentations). In attempting to clarify some confusion about estoppel, we held in *Coker* that the elements of ERISA-estoppel are: (1) a knowing misrepresentation by the defendant; (2) in writing; (3) with reasonable reliance by the plaintiff on the misrepresentation; (4) to the plaintiff's detriment. *Coker,* 165 F.3d at 585. As defined, ERISA-estoppel can encompass both the concept of promissory estoppel and the concept of equitable estoppel. *See id.* (noting that the proposed four-factor test for ERISA-estoppel encompassed "what has been implicit in all of our estoppel cases"). Finally, in *Bowerman,* we clarified that "oral representations of an ERISA plan may not be relied upon ... when the representation is contrary to the written terms of the plan and those terms are set forth clearly." *Bowerman,* 226 F.3d at 588. Therefore, all of Kamler's claims based on estoppel principles will be analyzed under

the *Coker* four-factor test.

Under the *Coker* test for ERISA-estoppel, Kamler faces several problems with his estoppel theories. The principal problem is that there is no allegation of knowing misrepresentations. Kamler does not allege that he was told by anyone that he did not have to enroll in the PAL Plan to receive medical benefits. Rather, at least one document sent to Kamler, the fax from Oliva, asked him to "fill out the requested forms." A promise to provide insurance is not a promise that Kamler would receive insurance even if he did not enroll. Similarly, a promise to answer privacy concerns is not a promise that Kamler could wait indefinitely to complete the enrollment process. At best, the alleged misrepresentations might *imply* that Kamler did not have to enroll, but, as discussed *infra,* it was not reasonable for him to interpret the alleged misrepresentations in that manner.

Kamler also cannot show that it was reasonable for him to rely upon the alleged misrepresentations to justify his failure to enroll. In his deposition, Kamler admits that he has never received disability or life insurance through a previous employer without filling out a form. Further, he testified that he never received an insurance card or certificate of insurance from PAL, the PAL Plan or Starmark, the plan administrator. Kamler also did not know the name of the insurer, the terms of coverage, the deductibles, the exclusions or the period of time the policy

covered. Finally, it was unreasonable for Kamler to interpret the alleged misrepresentations as excusing him from enrolling in the Plan because the PAL Plan documents unambiguously and clearly require enrollment as a precondition for coverage.

In interpreting an ERISA plan, we apply the federal common law rules of contract interpretation. *Neuma, Inc. v. AMP, Inc.*, 259 F.3d 864, 873 (7th Cir.2001). These rules "require us to interpret terms of ERISA plans in an ordinary and popular sense as would a person of average intelligence and experience." *Swaback v. Am. Info. Techs. Corp.*, 103 F.3d 535, 540-41 (7th Cir.1996). In attempting to interpret an ERISA plan, "our first task is to determine if the [documents governing the ERISA plan] at issue [are] ambiguous or unambiguous." *Neuma*, 259 F.3d at 873. "[I]f a document governing an ERISA plan is unambiguous, this court will not look beyond its 'four corners' in interpreting its meaning." *Id.*

After reviewing the PAL Plan documents, we believe that the documents clearly and unambiguously require an employee to enroll before the employee becomes eligible for medical benefits. The cover page of the policy issued by Trustmark, which governs the PAL Plan, states that: Trustmark "insures those Eligible Persons ... whose *applications* have been approved by the [insurance] Company and for whom the premium has been paid." Appellant's Separate Appendix (S.App.) 173 (emphasis

added). Section D of the policy states: "*Eligible Employees must apply for coverage* .... All applications must be made to the Company .... All applications must be made on forms acceptable to the Company." S.App. 176 (emphasis added). The "Participating Employer Application and Agreement" provides that eligible employees "must apply." S.App. 179. The Administration Guide, provided by Starmark, provides: "Each employee must complete, sign and date the Starmark Employee Enrollment Form ... in order to apply for coverage under the group insurance plan." S.App. 188. Finally, on the Enrollment Form, under the heading "Waiver of Coverage," there is a provision: "This is to certify that I have been given the opportunity to *apply* for group medical and/or dental coverage through my employer and I have decided not to *apply*. I understand that if I choose to *apply for this coverage in the future*, my application may be subject to individual medical underwriting, and I may be required to furnish evidence of insurability at my own expense." S.App. 194 (emphases added).

Whether Kamler did or did not intend to complete the enrollment process is irrelevant. It is undisputed that Kamler did not in fact complete the enrollment process. In light of the clear language of the PAL Plan, it was unreasonable for Kamler to interpret the representations by Lamplota, PAL or the PAL Plan documents as excusing enrollment. Thus, Kamler cannot satisfy the requirement of reasonable reliance.

A final problem with Kamler's reliance on estoppel is that some of the alleged misrepresentations were oral, and Kamler does not fit into the exception carved out by *Bowerman* for oral misrepresentations. In *Bowerman,* we permitted oral misrepresentations to be a basis for ERISA estoppel only if: (1) the ERISA plan was ambiguous and (2) an agent of the plan, or someone with apparent authority to interpret the plan, made the oral misrepresentations. *Bowerman,* 226 F.3d at 588. Here, the PAL Plan documents were not ambiguous about the requirement of enrollment for coverage. Further, it was unreasonable for Kamler to believe that Lamplota had apparent authority to modify the PAL Plan by excusing enrollment since the enrollment form clearly indicates that enrollment was mandatory and that any questions should be addressed to Starmark. *Cf. Bowerman,* 226 F.3d at 589 ("There is considerable force to the argument that, given the clarity of this particular direction, it was not reasonable for the [employee] to seek advice elsewhere.").

Thus, because Kamler cannot show that there was a misrepresentation and he cannot show reasonable reliance on any alleged misrepresentation, Kamler is not entitled to recover his medical expenses from the PAL Plan or from any other of the present defendants on any theory of estoppel. The shortness of the time he spent in Brazil, as a PAL employee, no doubt contributed to his difficulties with health insurance, but this factor does not change our analysis.

C.

Kamler also argues that he can recover his medical expenses under the PAL Plan because PAL, through its agent Lamplota, breached its fiduciary duties to him under the Plan. Kamler alleges that PAL breached its fiduciary duties when: (1) Lamplota assured Kamler that he would be covered by PAL's insurance from the beginning of his employment when in fact PAL imposed a 30-day waiting period, (2) PAL delayed in providing him with the enrollment form until May 6, 1998, (3) PAL provided him with a materially incomplete enrollment form because it omitted an allegedly crucial "Notice Under the Fair Credit Reporting Act" (FCRA notice), (4) PAL failed to inform him that enrollment was a requirement of coverage and (5) PAL failed to respond to his specific request for information about privacy concerns.

To be a fiduciary of an ERISA plan, an individual "must exercise a degree of discretion over the management of the plan or its assets, or over the administration of the plan itself." Under ERISA, a fiduciary must "discharge his interests with respect to a plan solely in the interest of the participants and beneficiaries." 29 U.S.C. § 1104(a)(1). Fiduciaries breach this duty "if they mislead plan participants or misrepresent the terms or administration of a plan." *Anweiler v. Am. Elec. Power Serv. Corp.*, 3 F.3d 986, 991 (7th Cir.1993). Not all errors in communicating information regarding a plan violate a fiduciary's duty

under ERISA, but "material facts affecting the interests of plan participants or beneficiaries" must be disclosed. *Bowerman,* 226 F.3d at 590. A plan participant may obtain individual "appropriate equitable relief" under 29 U.S.C. § 1132(a)(3) for a fiduciary's breach of fiduciary duties. *Varity Corp. v. Howe,* 516 U.S. 489, 508-15, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996). Finally, although not explicitly indicated by the prior caselaw, the plaintiff must allege that the breach of fiduciary duty caused some harm to him or her that can be remedied.

Here, none of the allegations support a claim for breach of fiduciary duty on the part of PAL or its agent, Lamplota. Lamplota's mistaken assurance that Kamler was immediately covered could be a breach of fiduciary duty only if Kamler had enrolled and was then denied medical benefits during the 30-day waiting period. This is a simple application of the principle of causality and the conditions of liability are not met here. Similarly, the delay in providing Kamler with the enrollment form would be a breach of a fiduciary duty only if Kamler had actually enrolled but then was denied medical benefits for the period prior to the date of enrollment. The failure expressly to inform Kamler that enrollment was a requirement of coverage was not a breach of fiduciary duty because the PAL Plan made this abundantly clear. PAL had no duty to emphasize something that had already been clearly communicated to Kamler.

Finally, the failure to provide a FCRA Notice[3] and PAL's failure to respond to Kamler's specific request for information about privacy concerns are breaches of fiduciary duty only if Kamler's indefinite delay in completing the enrollment process while waiting to have his privacy concerns addressed was reasonable. To make out a claim for a breach of fiduciary duty, Kamler would at least have had to allege that, if he had received the FCRA Notice (which the law did not require to be sent to enrollees) or if he had heard a reply from Lamplota on his privacy concerns, he would have completed the enrollment process. Kamler did not make these allegations in his Complaint and, since he never did receive the assurances that he needed, it becomes purely hypothetical whether he would have completed the enrollment process if he had been so reassured. In any case, we believe that it was not reasonable for Kamler to indefinitely delay enrolling in the PAL Plan while waiting to have his privacy concerns addressed because the PAL Plan documents clearly required enrollment as a precondition for coverage. Further, although Kamler had privacy concerns, he had no legal right not to furnish the information requested if he expected coverage. Since Kamler has been previously

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[3] Starmark usually sends a FCRA Notice attached to the enrollment form to inform enrollees that it was permitted under federal law to investigate the credit, medical history, character, general reputation, personal characteristics and mode of living of an enrollee and his or her family. In the present case, a FCRA Notice was not faxed with the enrollment form.

employed and had received insurance coverage from previous employers, he knew or should have known that insurance companies were entitled to such information. Thus, PAL did not breach any fiduciary duties that it owed to Kamler.

D.

Besides his claims under the alternative theories of estoppel and breach of fiduciary duty, Kamler also argues that he was entitled to medical benefits under the PAL Plan because his error in failing to enroll was covered by the clerical errors provision of the insurance policy issued by Trustmark that governs the PAL Plan. The relevant insurance provision states:

> Clerical error by a Participating Employer or by the Assured shall not invalidate coverage of a person insured. This includes error in enrolling, recording or reporting for coverage purposes. Any premium not paid because of the error must be paid in full at the time the error is corrected.

After careful review of this provision, we are convinced that it does not cover a failure to enroll. Rather, the provision is designed to deal with clerical errors, for example, where an enrollee puts a wrong social security number on his application. This is a far cry from that. Kamler's argument that this provision can be the basis of

relief (because the delay in getting the enrollment papers to him, the omission of the FCRA Notice and the failure to respond to his privacy concerns were all "errors in enrolling") is unpersuasive because, even if those alleged errors were "errors in enrolling," they were not the legal causes of Kamler's failure to enroll in the plan. Rather, it was Kamler's unreasonable response to those alleged errors that resulted in his failure to enroll. Hence, Kamler is not entitled to recover his medical expenses.

E.

Kamler also seeks civil penalties against PAL, the PAL Plan and Royal for failure to provide him with the PAL Plan documents he requested. Section 502(c) of ERISA, 29 U.S.C. § 1132(c), requires plan administrators to provide information requested by plan participants or beneficiaries within 30 days of such request, or face a statutory fine.[4] ERISA authorizes a plan participant or beneficiary to sue

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[4] 29 U.S.C. § 1132(c)(1) provides that:
Any administrator ... (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary ... by mailing the materials requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

for civil penalties if a plan administrator violates section 502(c). *See* 29 U.S.C. § 1132(a)(1)(A) ("A civil action may be brought ... by a participant or beneficiary ... for the relief provided for in [29 U.S.C. § 1132(c)]."). Whether to impose these statutory penalties is within the discretion of the district court and is reviewable only for abuse. 29 U.S.C. § 1132(c)(1); *see also Neuma,* 259 F.3d at 879. Here, the district court did not abuse its discretion in denying Kamler's motion for imposition of statutory penalties.

Kamler made the request for information to PAL and Royal, who are not the plan administrators, to whom section 1132(c) requires the request be made.[5] The request therefore should have been made to Starmark as plan administrator. The enrollment documents that were sent to Kamlermade this clear when they stated that the PAL Plan was administered by Starmark. That Kamler misplaced these documents due to his illness is unfortunate, but does

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[5] There is some dispute concerning whether Starmark is or is not a plan administrator. Under ERISA, where a plan administrator is not designated, the plan sponsor--in this case, PAL--is deemed the plan administrator. *See* 29 U.S.C. § 1002(16)(A)-(B). We believe that a reasonable reading of the PAL Plan documents indicates that Starmark was the plan administrator. In any case, the district court's refusal to impose statutory penalties on Starmark, PAL or Royal can be sustained based upon the lateness of Kamler's request and the outdated nature of the requested documents.

not excuse him from complying with the requirements of section 1132(c). Second, the fact that the requested documents were outdated (since the PAL Plan had been terminated prior to Kamler's request for information) and that the request for documents came more than a year and a half after Kamler incurred his medical expenses are additional reasons why there was no abuse of discretion.

III.

For the foregoing reasons, we AFFIRM the judgment of the district court dismissing Kamler's claims.

APPENDIX B

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

BRENT KAMLER,

Plaintiff,

v.

H/N TELECOMMUNICATION SERV., INC., *et al.*,

Defendants.

MEMORANDUM OPINION AND ORDER

Brent Kamler sues H/N Telecommunication Services, Inc., formerly known as Pal Telecom Group, Inc. ("Pal"), Pal Telecom Group, Inc. Employee Welfare Plan ("the Pal Plan"), Royal & Sunalliance ("Royal"), and Star Marketing & Administration, Inc. ("Starmark") (collectively "defendants") on a five-count complaint for violations of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq.*, and for common law claims. Count I is against the Pal Plan for failure to pay benefits under ERISA. Counts II and III are against Pal, Royal and Starmark for failure to respond to a request for information and failure to furnish information under ERISA respectively. Counts IV and V are against Pal for

promissory estoppel and breach of fiduciary duty. Defendants move for summary judgment.

BACKGROUND

I. The parties and their relationship

All facts are undisputed unless otherwise noted. Nestor Popowych, president of Pal, asked George Lamplota, director of project management, to hire three managers for construction of cellular telephone infrastructure in Brazil. Lamplota telephoned Kamler, whose resume was on file, for his initial interview. Kamler testified that he asked Lamplota for $95,000 a year salary, full medical benefits, and per diem expenses. Pl.Ex. 1 at 68-71. Kamler resides in California and asserts he demanded health insurance or he would not go to Brazil. *Id.* at 71, 87-89, 141. Lamplota allegedly responded that Kamler would be insured. *Id.* Lamplota denies he told Kamler this. Pal Ex. 7 at §§ 18-20. Kamler's recollection of their agreement was that he would receive full medical benefits before he left for Brazil.

Lamplota offered Kamler Pal's group health, life and disability insurance, but states Kamler objected to paying the premium. Pal Ex. 7 at §§ 7-8. Kamler denies he told Lamplota that he did not want Pal's health insurance if he had to pay for it. Pl.Ex. 1 at 72. Lamplota states he told Kamler Pal would not make an exception to the policy that new employees paid their own premium for the first 90

days, but Pal would consider paying it afterwards. Pal Ex. 7 at §§ 9-10. Kamler denies Lamplota told him this. Pl. Resp. Pal Facts at § 35. Pal asserts Kamler continued to refuse to pay the premium and stated he had COBRA coverage through his prior employer and they would revisit the issue later. Pal Ex. 7 at §§ 8-11. Kamler denies this. Pl.Ex.1 at 72. On March 17, 1998, Kamler signed a letter of commitment memorializing the agreement on his compensation package, but Kamler concedes the agreement is silent about insurance coverage. Kamler denies the letter of commitment was his entire agreement with Pal.

Two days later, Kamler left for Brazil. Lamplota obtained insurance enrollment forms and learned the estimated coverage date for Kamler was May 1, 1998. Pl.Ex. 8 at 80-81. The waiting period could be waived, but the request for waiver had to accompany the insurance enrollment form. Pl.Ex. 15, § 106 at 5. On March 30, 1998, Lamplota faxed the enrollment form and personnel manual to Victor Jaworski in the Brazil office with the following cover memorandum:

> Victor: Enclosed please find [Pal's] *Personnel Manual* and the *Employee Enrollment Form* (Insurance) to be forwarded to Brent Kamler ... [He] should fill out the Employee Enrollment Form and return it back to me as soon as possible, the coverage is to start by 05-01-1998 .. . .

Pal Ex. 7 at § 16; Pal Ex. 11 at PAL 53-76. Jaworski does not recall receiving the fax before May 1998. Pl.Ex. 9 at 40-41. On May 5, 1998, Lamplota resent the March 30, 1998 memorandum with the attachments to Jaworski. Pal Ex. 7 at § 22. On May 6, 1998, Jim Olivia faxed this information to Kamler's hotel in Brazil, with a cover note that read: "Hi Brent: I was asked by Victor [Jaworski] to follow up on George Lamplota's fax. Please fill out the requested forms and fax back to Sao Paulo office." Olivia then followed up with a phone call to Kamler. After Kamler received the enrollment form, he promptly called Lamplota with questions about it. Pl.Ex. 1 at 82-84, 93-94, 97-98. This was the first time Kamler discussed health insurance with Lamplota since his initial telephone interview in mid-March 1998. *Id.* Kamler told Lamplota he was concerned the form required him to release information about his family, including credit reports and medical information that he felt violated his right of privacy. Pl.Ex. 1 at 85-87, 159-160. Kamler asked Lamplota to verify the information that the insurance company wanted and why. *Id.* Lamplota told Kamler that he would contact the insurance company and call Kamler back. *Id.* According to Kamler, Lamplota failed to respond to Kamler's questions, and did not tell him that he would not receive coverage without filling out and submitting the form. *Id.* Lamplota does not agree with Kamler's recollection of these events. Pal. Ex. 7 at §§ 18-20.

Kamler asserts Starmark in fact did not conduct investigations of personal information about an employee

or his family. Pl.Ex. 4 at 82-84. Kamler's record cite does not fully support this assertion because Starmark only states it was not aware of any instance that an investigation was actually conducted. *Id.* Kamler also contends that Lamplota did not advise him to contact Starmark or anyone else for answers to his questions. Pl.Ex. 1 at 84-87, 154-55. The record does not support his contention because Kamler was not asked this specific question and offers no other support for the contention. *Id.*

The personnel manual's section on insurance states "medical life and long-term disability insurance are carried by the firm on a group basis for the benefit of its employees." Pal Ex. 4(a) at 141. This section is one of the reasons Kamler believed he was insured. Kamler never received disability or life insurance through a previous employer without filling out a form. Pal Ex. 4(a) at 135.[6] Kamler contends that he filled out a form for life insurance with some of his employers. Pl. Resp. Pal Facts at § 26; Pal Ex. 4(a) at 132- 35. But his testimony does not support this contention. Despite this, Kamler maintains he believed that as soon as he told Lamplota that he would not leave the country without insurance, he was insured. Pl.Ex. 4(a) at 89. Kamler also asserts Lamplota stated he would be

[6] Because Pal and the Pal Plan's exhibits in support of their motion for summary judgment contain two exhibits marked number 4, the court refers to the second exhibit as "Pal Ex. 4(a) at __."

insured. *Id.* at 71,87-90,110,141. Kamler never paid an insurance premium, and Pal never paid one on his behalf. Kamler asserts he was not required to pay a premium because the Pal Plan required Pal to pay 100% of the premium for each employee. Pl.Ex. 12, part IV(A) at 3. Kamler adds that he was not aware whether Pal was making payroll deductions for premiums because his checks were sent directly to the United States. Pl. Ex. 1 at 99,135-136. Kamler never received an insurance card or certificate of insurance. Although Kamler believed he was insured, he did not know the insurer, the terms of coverage, the deductibles, exclusions, or the period of time the policy covered. Kamler was laid off due to lack of work on June 3, 1998.

Two weeks later, Kamler had a heart attack. His hospital bill is blank where the form indicates insurance coverage. On August 4, 1998, Kamler submitted a claim to Pal for payment of the medical expenses and then to Royal. Kamler disagrees and asserts that Pal submitted his claim to Royal. Pl.Ex. 2 at 105-07; Pl.Ex. 3 at 12-13, 16. The record does not support this assertion. On March 6, 2000, Lamplota received a letter from Kamler's attorney requesting insurance documents. The letter was referred by Lamplota to Popowych and eventually to legal counsel. Pl.Ex. 8 at 191-92. Popowych left this matter to Lamplota and Royal to handle. Pl.Ex. 2 at 114,119. On November 24, 1998, Royal denied Kamler's claim based upon the results of its investigation. Kamler never contacted

Starmark, and no one requested information regarding the Pal Plan or submitted a claim for benefits to Starmark.

II. The Pal Plan

On November 8, 1988, Popowych Associates established an employee welfare benefit plan for eligible employees through participation in a group medical, life and disability insurance program underwritten by Trustmark Insurance Company ("Trustmark") (f/k/a Benefit Trust Life Insurance Company) with administration performed by Starmark. Popowych formed PAL in the early 1990s and covered the employees under the same plan ("the Pal Plan"). In 1995, Popowych received separate group numbers for Pal and Popowych Associates, but the terms, conditions, and coverage remained the same. In joining the Pal Plan, Pal determined, *inter alia,* the types of coverage to be provided, the eligibility requirements for its employees, employee premium contribution amounts, deductible and co-pay requirements and desired plan benefits. Pal served as the "plan sponsor" as defined in ERISA, 29 U.S.C. § 1001(16)(B); Pl. Ex. 13, 16-17; Starmark Ex. 1A. However, Pal denies it is the plan sponsor, implying Popowych Associates is the sponsor. Pal Br. at 7. The participating employer agreement states that the employer understands it is establishing this plan and neither Starmark nor Trustmark is the sponsor; any duties of the sponsor will be fulfilled by the employer. Starmark Ex. 1A.

No plan administrator was designated in the Pal Plan. Pal reserved the right to modify or eliminate the coverage carried for its employees' benefit. Starmark Ex. 3 at 10.

To be covered by the Pal Plan all eligible employees had to complete and sign an enrollment form, and have their premiums paid. Newly added members received the effective date for which they were eligible regardless of processing time and billing periods. Pl.Ex. 16. The Pal Plan includes the Trustmark insurance policy, the participating employer agreement, the certificate of insurance, the employer guide, and the personnel manual. The Pal Plan provides that Trustmark retains the right to amend and interpret the contract. Pal Ex. 4, part III(A), at 37, part IX(B),(C) at 45. Kamler adds that the participating employer agreement provides the employer requestsStarmark perform other administrative services as it and Starmark may agree upon in connection with the Pal Plan, provided no services shall involve the exercise of discretion by Starmark. Pal Ex. 5, part IV(B),(C) at 4.

Further, Trustmark retained the right to accept or reject an applicant for enrollment into the Pal Plan: "[N]o insurance will become effective without approval of Trustmark ... or its administrative representative [Starmark]." Pal Ex. 5, part IV(A) at 3. But since 1997, medical coverage was guaranteed; Starmark could not decline an employee medical coverage under the federal Health Insurance Portability Act ("HIPA"). Pl.Ex. 4 at 57-

58, 82-84. The participating employer agreement provides that eligible employees are those that work 30 or more hours per week. Pal Ex. 5, part II. The Pal Plan provides that all eligible employees must apply for coverage by filling out the enrollment form. Pal Ex. 4, part III(D)(1) at 39. If the employee applies before working 30 continuous days, his effective date is at the end of the 30- day period, and if he applies after this date, the effective date is the first day of the month following the date he applies. *Id.* The 30-day period could be waived by a request submitted with the enrollment form. Pl.Ex. 15, § 106 at 5. The enrollment form provides:

> To be completed by the employees only. Failure to provide complete facts may be cause for cancellation of your coverage as of its effective date.
> NOTE: As part of our routine underwriting procedure, you may receive a phone call . . . to obtain personal information needed to evaluate your insurability . . . Unless waived above, I request insurance under my employer's insurance plan ... I authorize my employer to make deductions from my earnings for my share of the cost, if any, for the benefits for which I may become entitled ...

Pal Ex. 11 at PAL 54-55; Pal Ex. 12.

The Pal Plan states that Trustmark will provide the

certificates of insurance for covered employees. Pal Ex. 4, part III(A) at 39, part IV at 42. The certificates describe benefits for an employee whose coverage has become effective and specify when and where the Pal Plan may be inspected. *Id.* They also summarize the main parts of the Pal Plan that affect him. *Id.* Pal was responsible for sending the certificates of insurance on to employees. Pl.Ex. 6 at 37-38. Pal does not determine or process claims. The certificate of insurance states:

> YOUR COVERAGE IS INSURED BY [TRUSTMARK] ... AND ADMINISTERED BY ITS AUTHORIZED REPRESENTATIVE, ... STARMARK. ALL CLAIMS SHOULD BE SUBMITTED TO STARMARK AND ALL QUESTIONS REGARDING YOUR COVERAGE SHOULD BE DIRECTED TO STARMARK

Pal Ex. 5, certificate at 1,26. After an employee filed out an enrollment form and was accepted by Trustmark, he received a certificate of insurance. Pal Ex. 4, part IV at 37-39, 42; Pal Ex. 5, part II & IV; Pal Ex. 11 at PAL 54-55; Pal Ex. 7 at § 2; Pal Ex. 8 at § 4; Pal Ex. 9 at § 2. Pal employees Sriver, Lamplota, and Olivia filled out the forms and also received insurance cards. Pl. Resp. Pal Facts at § 18.

Royal provided errors and omissions coverage to Pal with effective dates September 8, 1997 through September

8, 1998 that states:

> Coverage. We will pay those sums that the "insured" becomes legally obligated to pay as damages because of claims made against you by a[ ] former employee ... and caused by any negligent act, error or omission of yours, or any other person for whose act the "insured" is legally liable in the "administration" of your "Employee Benefit Programs."

Employee benefit programs include group life insurance, group health insurance and disability benefits. Administration is defined as giving counsel toemployees with respect to benefit programs; interpreting the employee benefit programs; handling of records in connection with the employee benefit programs; or effecting enrollment or cancellation of employees under the benefit programs provided, all activities are authorized by Pal. Starmark Ex. 8,9 at R25-27. Royal also provided commercial general liability insurance to Pal. Neither the commercial policy nor the errors and omissions coverage provided health coverage to Pal's employees.

In October 1999, CH2M Hill Telecommunications Group, LLP ("Hill") and Pal merged in a transitional merger, and in October 2000, Hill purchased Pal's assets. Pl.Ex. 2 at 9;Pl. Resp.Pal Facts at § 20. On December 31, 1999, the Pal Plan terminated. The Hill group plan uses a

different insurance carrier than the Pal Plan. On March 6, 2000, Kamler wrote to Pal and Royal to request Pal Plan documents. On March 20, 2001, he filed his second amended complaint against Pal, the Pal Plan, Royal, and Starmark.

DISCUSSION

I. Summary judgment standard

Summary judgment is proper when the moving papers and affidavits show there is no genuine issue of material fact and the movant is entitled to judgment as a matter of law. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). Once a moving party has met its burden, the nonmovant must go beyond the pleadings and set forth specific facts showing a genuine issue for trial. *Silk v. City of Chicago*, 194 F.3d 788, 798 (7th Cir.1999). The court considers the whole record and draws all reasonable inferences in favor of the nonmoving party. *Bay v. Cassens Transp. Co.*, 212 F.3d 969, 972 (7th Cir.2000). An issue of material fact exists when the evidence is sufficient to support a reasonable jury verdict in favor of the nonmovant. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

II. Standing under ERISA

For Kamler to have standing to bring a claim under ERISA, he must be a "participant" at the time he filed his

action. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 116 (1989). The term participant is defined as a "former employee ... who is or may become eligible to receive a benefit ... from an employee benefit plan." 29 U.S.C. § 1002(7). This definition includes former employees who have a reasonable expectation of returning to covered employment or who have a "colorable claim to vested benefits." *Firestone*, 489 U.S. at 117-18. Because Kamler is neither currently employed by Pal nor expected to be so employed in the future, his claim must rest on "a colorable claim to vested benefits." The requirement of a colorable claim is not a stringent one. *Panaras v. Liquid Carbonic Indus. Corp.*, 74 F.3d 786, 790 (7th Cir. 1996). Jurisdiction requires an arguable claim. *Id.; Kennedy v. Connecticut Gen. Life Ins. Co.*, 924 F.2d 698, 700 (7th Cir.1991).

Pal, the Pal Plan, and Starmark argue that where a former employee, like Kamler, never enrolled in or contributed to his former employer's benefit plan, he is not entitled to benefits under the plan and does not have a "colorable claim to vested benefits." *Saliee v. Rexnord Corp.*, 985 F.2d 927 (7th Cir.1993); *Loechl v. Illinois Bell Tel. Co.*, 648 F. Supp. 1178, 1180-81 (N.D. Ill.1986); *Rudman v. Time Ins. Co.*, 1995 WL 239390, at *9 (N.D. Ill. Apr. 21, 1995); *Freeman v. Jacques Orthopaedic & Joint Implant Surgery Med. Group*, 721 F.2d 654, 655 (9th Cir.1983). *Rudman* is inapposite because it concerns ERISA's preemption of common law claims and not the

term participant. In *Sallee,* the plaintiffs voluntarily left employment knowing their benefits would not vest unless they were provided a termination date. Thus, the court found they were not participants and lacked standing under ERISA. *Id.* at 929. Kamler argues that unlike the plaintiffs in *Sallee,* he was eligible for the Pal Plan benefits and the issue of enrollment is irrelevant to the question of eligibility. But *Loechl* and *Freeman* collectively hold that former employees not covered by a benefit plan at the time of their departure from the company *regardless of misrepresentations on the part of the employer's agents* are not participants under ERISA. Indeed, the reasons for failing to enroll in and have contributions made on one's behalf to a plan are considered irrelevant to whether an employee is a participant. *Boren v. Southwestern Bell Tel. Co., Inc.*, 933 F.2d 891, 893 (10th Cir.1991); *Smith v. Motherlode Plastics, Inc.*, 990 F.2d 1260, 1993 WL 83830, at *1-2 (9th Cir.1993)(table); *Pierchalaski v. Dr. Samuel P. Cimino, D.D.S. Assoc., Inc.,* No. 92-6373, 1993 WL 281064, at *1-2 (E.D. Penn. July 26, 1993);see *James v. National Bus. Sys., Inc.*, 924 F.2d 718 (7th Cir.1991). This is especially so because the Pal Plan is clear that no coverage exists for an employee absent an approved enrollment application and payment of premium by or on his behalf. *Burrey v. Pacific Gas & Elec. Co.*, 159 F.3d 388,395-96 (9th Cir.1998); Pal Ex. 4, part III § D(1) at 37-39, Pal Ex. 5, part II & IV, Pal Ex. 11 at PAL 54-55. Because Kamler never enrolled, no premium was paid and he has no standing under ERISA as a participant.

Kamler does not address *Loechl* or *Freeman,* but argues his claim is not frivolous. He contends that he was eligible for benefits under the Pal Plan because he worked 30 or more hours per week. Had his application been submitted before or after the waiting period, he would have been eligible for coverage on May 1, 1998. This period could be waived by a request accompanying the enrollment form. Regardless, Kamler did not fill out and submit the form. But Kamler contends Pal is estopped from denying coverage and breached its fiduciary duty because it provided him with misleading and incomplete information. *Bowerman v. Wal-Mart*, 226 F.3d 574 (7th Cir. 2000). *Bowerman* involved a plaintiff who participated in the employer's plan and then left to work elsewhere. The plaintiff received COBRA information, filled out and submitted the application. A month later, the plaintiff returned to her employer without receiving a notice regarding COBRA payments. The employer's plan provided that upon her return she would receive the same medical coverage she had before she left, and her employer said she was not required to pay for COBRA because she was gone a short a period of time. After experiencingproblems related to her pregnancy, the plaintiff submitted a claim. The plan denied the claim because the pregnancy became a pre-existing condition after her COBRA coverage lapsed due to nonpayment. *Bowerman* did not address the term participant.

But Kamler also argues that the failure to submit an

application for enrollment does not defeat his claim for benefits because there is a material issue of fact regarding whether a completed form should be excused by Pal's misconduct. *Epright v. Envtl. Res. Mgmt ., Inc. Health & Welfare Plan*, 81 F.3d 335, 340-41. *Epright* involved an employer that arbitrarily designated an employee as temporary, making him ineligible for health coverage. The court found the classification contradicted the plan's definition of a full time employee entitled to coverage. Further, the court decided the enrollment form was excused because the plaintiff made many inquiries about when his status would change and he would be eligible for coverage. The court noted it would be a different situation if the plaintiff knew he was eligible and did not complete the form through procrastination or indecision. *Id.* Kamler knew he was eligible, yet after receiving the form, stating that he must fill it out for coverage, along with two memoranda requesting Kamler to fill out the forms and submit them, he did not. *See Sallee,* 928-30 (plaintiffs own action deprived them of participant status); *Adamson v. Armco, Inc.*, 44 F.3d 650, 655 (8th Cir.1995).

According to Kamler, the enrollment form should be excused because he told Lamplota he would not leave the country without health insurance, and Lamplota told him he would be insured. The memorandum stating coverage was to begin May 1 and the accompanying documents with it contradict any continued belief by Kamler that coverage was automatic. Kamler states he was not informed he had

to fill out the form to be covered. But the memoranda sent with the form directed Kamler to fill out and return the form, and the form itself showed he had to fill it out to elect or waive coverage. Kamler claims the memorandum that stated coverage was to start May 1 misled him. However, the memorandum directed Kamler to fill out the form and return it as soon as possible. Kamler promptly called Lamplota with questions about the form and Lamplota promised to check with the insurer and to get back to him with answers, but failed to do so. None of these questions concerned whether Kamler had to fill out the form. Lamplota also did not tell Kamler to contact Starmark directly, but the form indicates the administrator of the Pal Plan is Starmark. Lamplota asserts he told Kamler that Pal never paid the first 90 days of health coverage, and that Kamler refused to pay and did not fill out the application. Kamler denies this and so cannot rely on it. Finally, because Starmark could not decline medical coverage due to HIPA, Kamler asserts the form is ministerial. Even if Starmark could not decline coverage, it still required a form to show election or waiver, and Kamler did not submit the form. Kamler is not a participant under ERISA and has no standing.

III. Failure to respond to a request for information

Because Kamler was not a participant in the Pal Plan, he is not entitled to receive plan documents. But even if Kamler were a participant, he would not be entitled to

fines for the lack of response. Kamler seeks fines under ERISA against Pal, Royal and Starmark for failure to furnish information in response to a request for information. 29 U.S.C. §§ 1024(b)(4),1132(c)(1), 1166(a)(1).[7] Kamler alleges in his complaint that Pal, Royal, and Starmark are the plan administrators of the Pal Plan. Pal, Royal and Starmark all deny they are the plan administrator, and therefore, cannot be held liable. 29 U.S.C. § 1132(c)(1); *Klosterman v. Western Gen. Mgmt., Inc.*, 32 F.3d 1119 (7th Cir.1994). ERISA defines administrator as either the person specifically designated by the plan or, if an administrator is not designated, the plan sponsor. 29 U.S.C. § 1002(16)(A). Kamler admits that the Pal Plan does not specifically designate the plan administrator. Pl. Resp. Starmark Facts at § 7. Thus, the plan administrator is the plan sponsor.[8]

Plan sponsor means the employer in a plan established or maintained by a single employer, or in a plan established and maintained by two or more employers, the

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[7] Kamler abandoned his claim against Starmark that sought a fine for failing to provide him notice of COBRA coverage rights. Pl.Resp.Br.at13n. 12. Kamler admits he was not eligible for COBRA because he did not work for Pal 90 days. Pl.Facts at § 61n.8.

[8] Pal also argues the Pal Plan does not designate a plan administrator and thus the plan sponsor is deemed the administrator. Pal Br.at 7. Royal argues it is not mentioned in the Pal Plan and so cannot have been designated the plan administrator.

group of representatives who establish or maintain the plan. 29 U.S.C. § 1002(16)(B). Starmark argues that Pal established the Pal Plan for the benefit of its eligible employees, that Kamler was employed by Pal, and as the employer, Pal was expressly designated the plan sponsor in the participating employer agreement. Starmark Ex. 1A, 3; Pl. Resp. Starmark Facts at §§ 6,8. Starmark concludes Kamler's former employer is deemed plan administrator. *Moran v. Aetna Life Ins. Co* ., 872 F.2d 296, 299 (9th Cir.1989).

Kamler responds that Starmark and its co-defendants create an issue of fact by pointing to each other as the plan administrator. However, Pal does not state Starmark is the plan administrator in its motion for summary judgment; rather, Pal has not conceded it is the plan sponsor and therefore the plan administrator. Kamler argues there is a question of fact regarding whether Starmark is the plan administrator due to Starmark's exercise of alleged discretionary authority. However, the extent of a party's discretionary authority is only relevant to the question of fiduciary status under ERISA, and has no bearing on the question of whether the party is the plan administrator. The plan administrator is only the specifically designated party or the plan sponsor. 29 U.S.C. § 1002(16)(A)-(B). Indeed, the cases Kamler cites on this point examine discretion to determine whether a party was a fiduciary in a breach of

fiduciary duty claim.[9] No court examined discretion as a means of identifying the plan administrator, as Kamler asks this court to do. *See e.g. Plumb*, 124 F.3d 849; *Klosterman*, 32 F.3d 1119; *Estate of Bratton v. National Union Fire Ins. Co.*, 215 F.3d 516 (5th Cir.2000).

Moreover, Starmark argues that to the extent Kamler contends references in documents to Starmark's administration of the group insurance that funded the Pal Plan amounts to a designation of a plan administrator, Kamler undercuts his own claim.[10] ERISA only applies to a plan administrator who "fails or refuses to comply with a request for information." 29 U.S.C. §§ 1024(b)(4), 1132(c)(1). A participant must send a written request to the plan administrator in order to trigger its disclosure obligations. *Verkuilen v. South Shore Bldg. & Mortgage Co.*, 122 F.3d 410,412 (7th Cir.1997). If after 30 days the administrator has not replied, the participant may file suit to pursue a fine. *Id., see* 29 U.S.C. § 1132(c)(1). Because requesting ERISA information is simple and explicit, strict

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[9] *Vega v. National Life Ins. Serv., Inc.*, 145 F.3d 673 (5th Cir.1998), cited by Kamler to argue the exercise of discretion determines the identity of the plan administrator was vacated. 188 F.3d 287 (5th Cir.1999) (*en banc*).

[10] Starmark argues that the references to itself in documents establish, at most, that it provided administrative services for the group insurance program that funded the Pal employee welfare benefit plan and did not "specifically designate" Starmark as the Pal Plan administrator. Starmark Facts at §§ 10, 28.

compliance is required. *Verkuilen,* 122 F.3d at 412; *Jones v. UOP*, 16 F.3d 141, 144-45 (7th Cir.1994); *Kleinhans v. Lisle Sav. Profit Sharing Trust,* 810 F.3d 618,622 (7 thCir.1987). Thus, a plaintiff's claim for fines may be dismissed where, as here, the participant does not show it requested the information from the proper party, or that the defendant was required to provide the participant the information. *Id.* Kamler received the enrollment form by May 6, 1998 and noted that the plan was administered by Starmark. Pl.Facts at § 19. Despite this, Kamler never contacted Starmark for information. If his argument is correct and these words specifically designate Starmark as plan administrator, Kamler has no excuse for not requesting documents from Starmark. Jones, 16 F.3d at 144.

Kamler responds that Starmark was the agent of the plan administrator and should be liable for the plan administrator's failure to comply with his request. But Kamler never alleged that Pal or Royal was Starmark's agent. Compl.at §§ 5,22-23. At the summary judgment stage, Kamler is held to the allegations of his complaint. *See Soo Line R.R. Co. v. St. Louis S.W. Ry. Co.*, 125 F.3d 481, 483 (7th Cir.1997); *Joan W. v. City of Chicago*, 771 F.2d 1020, 1024 (7th Cir.1985). Moreover, Starmark cannot be liable because Kamler's request was made in March 2000, after the Pal Plan terminated and Starmark no longer had any responsibility for it. *See Jackson v. E.J. Brach Corp.*, 937 F. Supp. 735, 741 (N.D. Ill.1996) (listing

relevant factors for determining whether a fine should be imposed because of wrongdoing by the party who received the request). The purpose of levying fines is to "induce plan administrators to respond in a timely manner to a participant's request for information." *Id.* Thus, it is "improper to place a primary focus on the impact to the participant rather than the administrator's conduct." *Id.* This purpose would not be served by levying fines against Starmark.

Pal contends that although it was Kamler's employer, the entity designated in the Pal Plan as the employer in the participating employer agreement is Popowych Associates. Pal and Popowych Associates are separate companies. Thus, Pal intimates that Popowych Associates is the plan sponsor. Pal Br. at 8.[11] Pal as Kamler's employer participated in the Pal Plan. Pal asserts it delegated the responsibility of providing copies of plan documents to Starmark, so it is Starmark's duty. *Palmer v. University Med. Group*, 994 F. Supp. 1221, 1240-41 (D.Or.1998). *Palmer* did not impose a penalty on the employer because the third party administrator had the documents. *Id.* at 1241. The plan provides Starmark is to retain the documents and provide copies to those who ask for them, and importantly, the certificates issued to participants

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[11] Notably, Kamler does not seek to prove Pal or Starmark is the plan administrator. Rather, he sets up arguments against Pal and Starmark and concludes the issue is a fact specific inquiry. Pl. Resp. Br. at 13-17.

direct them to contact Starmark for copies. Pal Ex. 4, part IV at 37-39,42; Pal Ex. 5 at 1,26. Kamler did not receive a certificate because he was not a participant.

Finally Pal and the Pal Plan argue that even if a request for information was made to the plan administrator, the Pal Plan is no longer in existence so there is no obligation to produce the documents. *Jackson* reasoned a plan administrator is not required to provide outdated documents at a plaintiff's request. 937 F. Supp. 735. *Jackson* stated that plan administrators are instructed to furnish a copy of the latest plan, but refused to impose a penalty for failing to provide documents with no current application.

Pal merged with Hill in October 1999. On December 31, 1999, the Pal Plan terminated. The former employees of Pal who were hired by Hill then sought coverage under Hill's benefit plan. Kamler received the enrollment form with Starmark listed as the administrator by May 6, 1998. Starmark's address was on the form. Kamler retained an attorney by August 4, 1998 when he sent his request for payment of medical bills to Pal. Yet, Kamler waited until March 6, 2000, after the Pal Plan was no longer in effect and Pal merged into Hill to request the documents. The purposes of ERISA are not effectuated by assessing a penalty at this late date, more than a year and a half after Kamler's employment terminated, his heart attack occurred and first request for payment through an attorney.

Royal argues that the plan documents do not even mention it and thus it was not designated the plan administrator. Further, Royal was not Kamler's employer. Finally, Kamler no longer argues Royal is the plan administrator. Pl. Resp. Br. at 13-17. Thus, Royal is not the plan administrator and Kamler's claim for fines fails. *Klosterman*, 32 F.3d at 1120; *Moran*, 872 F.2d at 299-300. Kamler asserts that because he was unaware of Starmark and submitted his claim to Royal and Royal considered the claim and directed all communications to it, Royal is estopped from denying responsibility to provide requested plan information. Kamler received the enrollment form in May 1998 that stated Starmark administered the plan and Trustmark insured it. Yet he requested documents from Royal and Pal. Without evidence, Kamler argues the plan administrator delegated the responsibility to Royal to produce health plan documents. But Royal did not insure, provide, administer, or possess these documents. Kamler's failure to review his own documents, indicating Starmark as administrator, cannot form the basis for estoppel.

Kamler argues the out-dated document rule is inapplicable here because he submitted his claim in August 1998 and was frustrated at every turn in his quest to perfect his claim for damages by Pal's concealment and obstruction. Without any evidence support, Kamler's claim fails.

IV. Promissory Estoppel

Kamler asserts that Pal is estopped from denying him coverage under the Pal Plan based on misrepresentations made by Pal employees. Pal argues that for estoppel to apply, Kamler must show Pal made a knowing written misrepresentation with reasonable reliance by Kamler on the misrepresentation. *Downs v. World Color Press*, 214 F.3d 802, 805 (7th Cir.2000); *Coker v. TWA*, 165 F.3d 579,585 (7th Cir.1999). In the context of ERISA, estoppel is problematic given the requirements that modification of a plan occur in writing and through the procedures for amendment. *Shield v. Local 705, Int'l Bhd. Of Teamsters Pension Plan*, 188 F.3d 895,903-04 (7th Cir.1999);*Coker*, 165 F.3d at 585. Kamler seeks to rely on his statement during his interview for employment that he would not leave for Brazil without coverage and Lamplota's asserted reply that he would be covered; the personnel manual that provides medical insurance is carried by the firm on a group basis for the benefit of its employees, and the March 30, 1998 memorandum that stated in part, "the coverage is to start by 05-01-98." Kamler cannot rely on the statements because oral modifications of an ERISA plan are prohibited. Plum, 124 F.3d at 856; *Pohl*, 956 F.2d at 128. Further, although written modifications of an ERISA plan are permissible, a plan may only be amended pursuant to its express terms. *Brewer v. Protexall, Inc.*, 50 F.3d 453, 457 (7th Cir.1995). Pal contends that Kamler's suggestion that the enrollment form should be excused is a modification to the Pal Plan, and he has not shown this modification complies with the plan's amendment

procedures. Further, Kamler's assertion that the personnel manual is a written misrepresentation or modification of the Pal Plan would create absurd results. According to Kamler's interpretation, Pal was required to provide medical insurance to all its employees incident to their employment (regardless of whether they wanted it or not) and without application or payment of premiums.

Finally, the documents Kamler received, including parts of the plan, are not ambiguous. The March 30, 1998 memorandum states in relevant part:

> Enclosed please find enclosed ... the *Employee Enrollment Form* (Insurance) to be forwarded to Brent Kamler ... [He] should fill out the ... Form and return it back to me as soon as possible, the coverage is to start by 05-01-1998....

Pal Ex. 11 at PAL 53-76. Additionally, the cover memorandum from Olivia states: "Please fill out the requested forms and fax back ... "Pal Ex. 9 at §§ 4-5. Moreover, the enrollment form provides:

> To be completed by the employees only. Failure to provide complete facts may be cause for cancellation of your coverage as of its effective date. NOTE: As part of our routine underwriting procedures, you may receive a phone call ... to obtain personal information needed to evaluate your

> insurability ... Unless waived above, I request insurance under my employer's insurance plan ... I authorize my employer to make deductions from my earnings for my share of the cost, if any, for the benefits for which I may become entitled ...

Pal Ex. 11 at Pal 54-55; Pal Ex. 12. Read as a whole, these forms clearly do not promise automatic insurance coverage.

Furthermore, Kamler had a duty of due diligence to exercise available means of self-protection and failed to do so. *Andre v. Salem Technical Serv.*, 797 F. Supp. 1416 (N.D .Ill. 1992);see *Pohl*, 956 F.2d at 128-29. In *Andre,* an employee brought suit against two prior employers claiming ERISA required one of them to provide him retroactive health coverage. He was denied coverage because he was not yet officially enrolled in its health plan. The document the employee relied on in *Andre* made no promises of enrollment. Rejecting the plaintiff's estoppel claim, the court noted that "... ERISA bars only material representations. It does not impose an affirmative duty to explain benefit plans with the utmost clarity. Thus, an employee's lack of care in reading corporate documents does not support the proposition that the company has misled the employee." *Id.* at 1428. The March 30, 1998 memorandum stating coverage was to begin on May 1 is at odds with Kamler's belief that he was covered as soon as he accepted employment. Kamler was aware of the need

for insurance. Yet he did not apply for the Pal Plan or make sure a premium was paid on his behalf. Nor did the written employment agreement provide that Pal would cover Kamler free of charge and without any election for coverage.

A plaintiff may not rely on an oral representation when it is contrary to the written terms of the plan and those terms are set forth clearly. If the written documents are ambiguous, estoppel can be established by proof that a participant was misled by oral statements and conduct of the plan's agent. *Bowerman*, 226 F.3d at 588; *Black v. TIC Inv. Corp.*, 900 F.2d 112, 115 (7th Cir.1990). Although Kamler is not a participant, he argues his situation falls squarely in *Bowerman'* s holding. Kamler contends that nothing in the documents he received disclosed he would not be covered unless the enrollment form was completed and submitted to Starmark. He argues that the personnel manual confirmed his coverage by stating that medical insurance is carried by the firm on a group basis for the benefit of its employees and Lamplota's memorandum that Kamler's health insurance coverage was to start on May 1, 1998. Kamler argues Pal is estopped by these written representations that he was covered even if different from the enrollment provisions of the insurance contract itself. However, the documents in question are not ambiguous. The memoranda he received and the enrollment form instructed him to fill out the form and submit it to Pal. The personnel manual that states medical insurance is carried

by the firm on a group basis for the benefit of the employees and statement that Kamler's coverage was to start by May 1 do not create an ambiguity. There is nothing in the personnel manual that indicates coverage was automatic. Further, the March 30, 1998 cover memorandum does not promisecoverage without filling out the form. Finally, the Pal Plan's terms are clear that Kamler had to enroll for coverage.

Kamler also argues he reasonably relied on representations in the personnel manual and Lamplota's memorandum that he was covered, and Lamplota's alleged promise that Kamler would have health coverage prior to his departure from the United States. Without any analysis, Kamler string cites to numerous cases and argues his situation is analogous. Each of these cases, however, involved a participant in the plan at issue. Thus, they are irrelevant. Further, because the plan documents are unambiguous, Kamler's reliance is unreasonable. Finally, Kamler responds that requiring him to exercise self-protection has been rejected as a defense, citing *Schleibaum v. K Mart Corp.,* 153 F.3d 496,502 (7th Cir.1998). *Schleibaum* is inapposite. It dealt with mitigation of damages and not the issue of liability. Without any support in the record, Kamler concludes that Pal prevented the occurrence of a condition precedent to coverage, enrollment in the Pal Plan, and so Pal may not stand on that condition's nonoccurrence to escape the consequences of promissory estoppel. *Bowerman*, 226 F.3d

at 587. Nothing Pal did prevented Kamler from completing the enrollment form.

V. Breach of Fiduciary Duty

ERISA defines the term "fiduciary" as a person who exercises any discretionary authority or control respecting the management of a plan or who has any discretionary authority or responsibility in the administration of a plan. 29 U.S.C. § 1002(21)(A). The court first determines whether a person is a fiduciary with respect to the particular activity at issue. *Leigh v. Engle*, 727 F.2d 113, 133 (7th Cir.1984). Pal had no discretion with respect to Kamler's obligation to fill out the enrollment form. In fact, the form indicates only Kamler as the employee could fill it out. Pal Ex. 11 at PAL 54. In *Andre,* the court reasoned an employer's duty of due diligence under ERISA is greatest when:

> [T]he employer assumes the responsibility for things that only the employer can do ... But an ... employee's attempt to enroll in a welfare benefit plan presents a different situation, one where typically the agent has no discretion and the principle has a normal capacity for self protection. [citation omitted]. Here [the employer] had no discretion-only the ministerial responsibility of doing paperwork necessary to get [the employee] enrolled with [the insurer]. And as for [the

> employee], he had numerous means of self-protection available to him ... [I]f he had attempted to confirm his enrollment ... the [employer] could and would have corrected the initial problem and gotten him enrolled. He did no[thing] until after his heart attack, although a number of red flags had gone up before that time: no insurance deductions were taken from his paycheck, the promised "insurance package" never arrived and he never received an insurance card of the type that large insurers typically issue.

Id. at 1425. Kamler had numerous means of self-protection but did nothing. He did not fill out and return the enrollment form; he did not verify deductions were taken from his check; he did not receive a certificate of insurance or insurance card nor inquire why.

Kamler responds that if the plan documents do not specify the plan administrator, then Pal as the plan sponsor is the plan administrator. Kamler argues that by definition the plan administrator is a fiduciary. 29 U.S.C. § 1002(21);Dep't of Labor Reg. § 2509.75-8,Ques.D-3 & FR-12,40 (Oct. 9,1975). Kamler contends that Lamplota acted as Pal's agent for Kamler's enrollment in the Pal Plan and Lamplota communicated interpretations of the Pal Plan to Kamler. Pal Answer at § 13. Without any authority, Kamler argues that even though Lamplota's information and interpretations were incorrect, they constitute the

exercise of discretionary authority about the terms of the Pal Plan, including eligibility and enrollment. None of Lamplota's statements, however, excused Kamler from submitting an enrollment form.

Under ERISA, a fiduciary must "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries ... [with] care, skill, prudence, and diligence." 29 U.S.C. § 1104(a)(1)(B). Kamler argues that a fiduciary that denies its fiduciary status is not acting in the participants' best interests. An ERISA fiduciary also has the duty to adhere to the terms of the plan. *Cutting v. Jerome Foods, Inc.*, 820 F. Supp. 1146, 1153 (W.D. Wis.1991). Kamler asserts Pal breached its duty by telling him Pal would not pay the first 90 days of premiums contrary to the terms of the Pal Plan. Kamler denies Lamplota told him this and so cannot rely on it as a breach of fiduciary duty. Kamler argues fiduciaries have a duty to communicate material facts to employees. Fiduciaries breach this duty "if they mislead plan participants or misrepresent the terms or administration of a plan." *Bowerman*, 226 F.3d at 590. Fiduciaries must communicate material facts affecting the interests of plan participants and this duty to communicate exists when a participant " 'asks fiduciaries for information, and even when he ... does not." ' *Id.* (citing *Anweiler v. American Elec. Power Serv. Corp.*, 3 F.3d 986, 991 (7th Cir.1993)). Kamler contends his testimony establishes Pal breached its fiduciary duties in several ways. First, Lamplota assured

Kamler that he would be covered by Pal's insurance from the beginning of his employment when in fact it imposed a 30-day waiting period. But this period could be waived by request submitted with the enrollment form, and the waiting period would not have affected Kamler's claim. Next, Pal neglected to provide Kamler with an enrollment form at the beginning of his employment. Pal then informed Kamler coverage was to start by May 1, 1998 without informing him the form was necessary. Finally, Pal did not respond to Kamler's request for information about the enrollment form. These assertions are immaterial. *Andre,* F. Supp. at 1424-27. The documents Kamler received clearly indicated he had to fill out the enrollment form and return it for coverage. Nothing Lamplota allegedly did or did not do suggested otherwise.

CONCLUSION

The motions for summary judgment are granted.

ENTER:

/s/
Suzanne B. Conlon
United States District Judge

June 25, 2001

APPENDIX C

United States Court of Appeals
For the Seventh Circuit
Chicago, Illinois 60604
November 8, 2002

Before
Hon. Richard D. Cudahy, *Circuit Judge*
Hon. John L. Coffey, *Circuit Judge*
Hon. Ann Claire Williams, *Circuit Judge*

BRENT KAMLER,

Plaintiff-Appellant,

v.

H/N TELECOMMUNICATION SERVICES, INC., formerly known as PAL TELECOM GROUP, INC., formerly known as PAL WIRELESS DEVELOPMENT GROUP, INC.; ROYAL & SUNALLIANCE; and PAL TELECOM GROUP,INC., AND XYZ EMPLOYEE BENEFIT PLAN,

Defendants-Appellees.

ORDER

On consideration of the petition of appellant for rehearing with suggestion for rehearing *en banc* filed September 30, 2002, in the above captioned case, no member of the court requested a vote on the en banc request, and all judges on the panel have voted to deny a rehearing.

Therefore, the petition for rehearing with suggestion for rehearing en banc is DENIED.